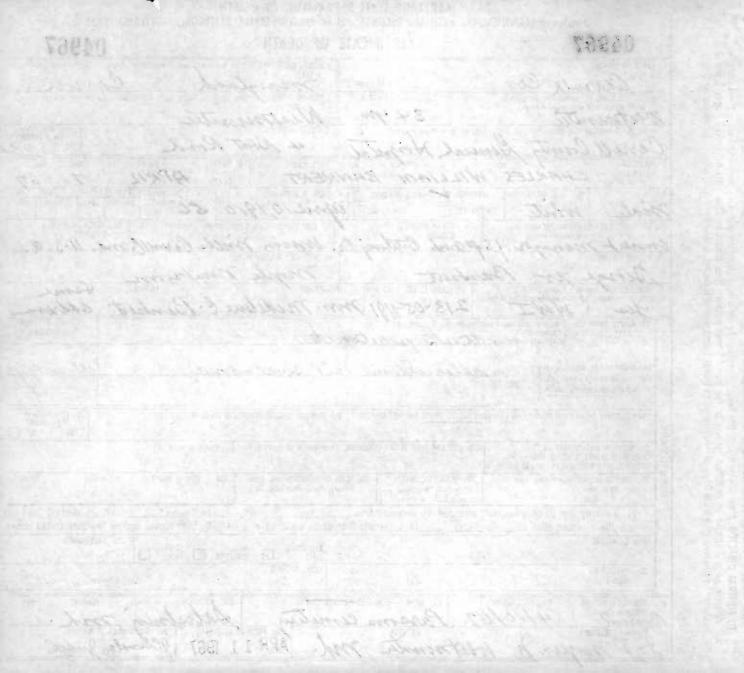
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04967 CERTIFICATE OF DEATH funeral 1 ond 2 ter death. death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. COUNTY a. COUNTY a, STATE requires that the death certificate be executed within 24 hours after MARYLAND filled in by the fun papers. Pages 1 c. LENGTH OF STAY IN 16 b. CITY OR TOWN (If outside carporote limits, c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) write RURAL and give pearest town) IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS YES NO cafbon 3. NAME OF Last DATE Month Day Year DECEASED OF CHARLES BANKERT 1967 (Type or print) DEATH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED remove birthday) Months Dovs Hours DIVORCED WIDOWED 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR RIRTHPLACE (County & State, or foreign country) **COUNTRY?** during most of working life, even if retired) owner + manager 13. FATHER'S NAME or removal 17. INFORMANT Vame WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dates of service) cremotion, CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN signed by the burial-tronsit p burial, cremotic the ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) coll caranoma Canditions, if any, which gove rise to immediate couse (a), DUF TO for use as the k f Health prior to b stoting the underlying cause has been last. WAS AUTOPS'
PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION NO YES O FUNERAL DIRECTOR: After this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING detached f te Dept. of I OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Yeor Hour o.m. foctory, street, office bldg., etc.) Nat While ot work ot work 1967, that (1) (we) last 21. I certify that (1) (this haspital) attended the deceased fram dept 1966 to april 7. 19 6), and that death accurred at 1. 2 PM, fram causes and an the date stated above saw the deceased alive an and 7. 22o. SIGNATURE 22b. DATE SIGNED ATTENDING director, poge 3 should be filed v M.D. DIRECTOR PHYS PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) (State) 23o. BURIAL, CREMATION 23b. DATE THEREO NAME OF CEMETERY-OR-CREMATOR MOCATION (City or Town) (County) REMOVAL (Specify)

VR A15 (4)

24. EUNERAL DIRECTOR

REC'D BY REGISTRAR

25b. REOTSTRAR'S SIGNATURE



6-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

	0496	8		CERTIFICAT	TE OF	DEATH			0496	8
F	1. PLACE OF DEATH						Where deceased lived,		Residence befa	re admissian)
	a. COUNTY	arroll		MARYLAND	0.	STATE	Md.	b. COUNTY	Carr	וויי
	b. CITY OR TOWN	(If autside carparate limit	ts, c. l	ENGTH OF STAY IN 1b	c. CIT	OR TOWN (If a	utside carparate limits,	write RURAL o		
		nd give nearest town)				Han	mostead		11.1	
. 1	d. NAME OF HOSPITAL DR INSTITUTION (If not in haspital			reet address)	d. STI	EET ADDRESS	inpanead		061	e. IS RESIDENCE
00	1000					7	on Ohannah			ON A FARM? YES NO
=	3. NAME OF	Co. General	nospt.	Middle	1 2	Lost Par	In Street	Month		
	DECEASED	Ida		lema	Be		OF	LL	Day	Year 7
-	(Type ar print) S. SEX	6. COLOR OR RACE				OF BIRTH	9. AGE (I		UNDER I YEAR	IF UNDER 24 HRS
	Female	White	7. MARRIED	NEVER MARRIED			last b		onths Days	Haurs Min.
			WIDOWED 🔀	DIVORCED		22, 1890		Yrs.		
		N (Give kind of work done	10b. KIND OI	BUSINESS OR	11. B		& State, ar fareign cau	ntry)	12. CITIZEN OF	
	during most of working Housew	ife	11150311				ll Co. Md.		COUNTRY?	
	13. FATHER'S NAME	4-314		A STATE OF THE STA	14. M	DTHER'S MAIDEN	NAME			
	Jona	s Lippy				Emi.	Ly Lowe			
	IS. WAS DECEASED EV	ER IN U.S. ARMED FORCES?	16. SOCIA	L SECURITY NO. 17.	. INFORM.			Address		
	(Yes, no. prunknawn)	(If yes give war ar dates	of service) 278-	32-5104 M	o Or	ion E. I	Relt Carr	ollton,	Md.	
	Canditians, if an rise ta immedia stating the undust.	te cause (a), erlying cause	10 (b) RHEU1 TO	ESTIVE MATIC H					Yi	SET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WA PER								PERFORMED?		
	Z Z		UARY	EMPHY	SEL	77			Y	ES NO
	DR CONTRIBUTING	AS UNDERLYING GCAUSE DF DEATH Y MEDICAL EXAMINER)	205. DESCRIB	E HOW INJURY OCCURRED	D. (Enter no	iture at injury in	Part I ar Part II at ite	m 18.)		
	Hour o	JURY Manth, Day, Year .m. 19	20d. INJURY While at wark			JURY (Hame, farn t, affice bldg., etc.		tawn)	(County)	(State)
		ify that (1) (this has		the deceased fram_	3	25	19 <u>67</u> , ta	4/1	, 1967, th	nat (L) (we) lo
	saw the	deceased alive an_	4/1	19 <u>67</u> , and th	at deat	accurred at	943 M, fram			
	22a. SIGNATURE 22c PHYSICIAN NAME (Typ	seent of	hioc	ag 1	M.D. PH	ENDING YS. d. ADDRESS		AFF HYS.	22b. DATESIGN	67
=	23a. BURIAL, CREMAT	ON, 23b. DATE TH	EREOF 23	c. NAME OF CEMETERY O	R CREMATO	DRY	23d. LOCATION (City ar Tawn)	(Caunty	r) (State)
)	Burial Specif	y) April	5.1967	Wesley Cen	neter	У	Carr	oll Co.		
	24. FUNERAL DIRECT			ADDRESS		2So. REC'	D BY REGISTRAR	25b, REGISTE	RAR'S SIGNATUI	RE
13	Tinton-	Fline Funer	al Home	Hamnetand	Md	LADR	5 1967	Illia	reas fo	10

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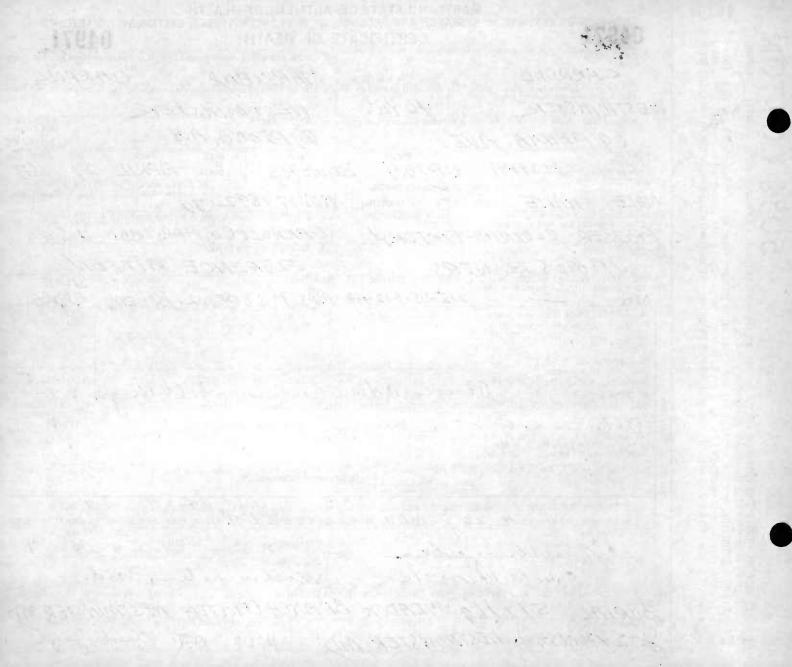
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04970 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. death funeral ond PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) O. STATE b. COUNTY papers. Pages I vin 72 hours after MARYLAND b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) in by URAL d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A EARM? BARK V NO [YES remove corbon NAME OF Middle 4. DATE event, wit Last Month Doy Year DECEASED OF DEATH (Type ar print) S. SEX IF UNDER 1 YEAR IF UNDER 6. COLOR OR RACE 7. MARRIED DATE OF BIRTH AGE (In years NEVER MARRIED last birthday) Manths Doys Hours in any WIDOWED DIVORCED ond 10b. KIND OF BUSINESS OR 10a. USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT . BIRTHPLACE (Caunty & State, or foreign country) please during most of warking life, even if retired) INDUSTRY NJ /V COUNTRY? physicion ond 13. FATHER'S NAME ARYLAND 14. MOTHER'S MAIDEN NAME cremotion, or removal, offending phys WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT 17. Address (Yes, na, ar unknown) (If yes give war ar dates of service) 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN buriol-tronsit ONSET AND DEATH IMMEDIATE CAUSE (a) signed by **O HOSPITAL OR ATTENDING PHYSICIAN:** The low requires the Page 4 may be retoined by the hospitol or attending physicion. 4221 DUF TO Conditions, if any, which gave rise to immediate cause (a), DUF TO stoting the underlying couse has been be detoched for use as the Stote Dept. of Heolth prior to 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) CERTIFICATION YES | NO **DIRECTOR:** After this certificate 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 1B.) (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or tawn) 20f. (County) (State) factory, street, office bldg., etc.) Nat While at wark at wark 4/14/47, 19_, that (1) (we) Tast 21. I certify that (I) (this haspital), attended the deceased fram 1140,19 director, page 3 should should be filed with the and that death accurred at 12.30 PM, from causes and on the date stated above. saw the deceased alive on 22a. SIGNATURE 22b. DATE SIGNED ATTENDING M.D. PHYS. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S TO FUNERAL NAME (Type) 230. BURIAL, CREMATION, REMOVAL (Specify) 23c. NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) (State) 256 REGISTRAR'S SIGNATURE FUNERAL DIRECTOR VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH uneral and 2 death. death. 1. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY h. COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE 24 ON A FARM? completely fill PENNA AU NO NAME OF First Middle Last DATE Month Day Year DECEASED APRIL 1967 (Type or print) DEATH executed SEX DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS NEVER MARRIED last birthday) remov Months I Days Hours DIVORCED WIDOWED 10a. USUAL OCCUPATION (Cive kind of work done | 10b. KIND OF BUSINESS OR physician n please r val, and in 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? pe during most of working life, even if retired) INDUSTRY CLOTA death certificate FATHER'S NAME MOTHER'S MAIDEN NAME remova 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT MME 0 (Yes. no, or unkown) | (If yes give war or dates of service) igned by the att rial-transit perm rial, cremation, c No 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN PHYSICIAN: The law requires that the the hospital or attending physician. ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) been signed the burial-tr DUE TO Conditions, If any, which (b) gave rise to Immediate has been as the b DUE TO cause (a), stating underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART (1a) WAS AUTOPSY for use Health PERFORMED? CAT YES 7 NO 20a. ACCIDENT WAS UNDERLYING DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.) etached f Dept. of OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) det le D factory, street, office bldg., etc.) Hour a.m. After d be d State Not While OR ATTENDING be retained by at work at work DIRECTOR: At age 3 should lied with the S to 4-27 21. I certify that (1) (this hospital) attended the deceased from Oct. 17 1945 194 7, that (I) (we) last and that death occurred at 30/M, from the causes and on the date stated above. saw the deceased alive on 4-26 1967 22a. SICNATURE 22b. DATE SIGNED page ATTENDING PHYS. Page 4 may b M.D. DIRECTOR PHYS. o FUNERAL director, pa should be fil PHYSICIAN'S 22d. ADDRESS NAME (Type) NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION. 23b. 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) 2 FUNERAL DIRECTOR ADDRESS REC'D BY RECISTRAR RECISTRAR'S SIGNATUR 25b. VR A15 (4) 1/65



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04972 CERTIFICATE OF DEATH low requires that the death certificate be executed within 24 hours after death. completely filled in by the funeral and we carbon popers. Pages I and yevent, within 72 hours after deat PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE b. COUNTY Carrobl Maryland Baltimore 6ity MARYLAND b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn)

Sykesville CLENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn) Baltimore vears d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS Springfield State Hospital 61 E. Randall Street YES NO THE 3 NAME OF Middle First Last 4. DATE Manth Year DECEASED Pearl Callender Jacobs 67 (Type or print) DEATH 19 S SFX 6. COLOR OR RACE 9. AGE (In years IF LINDER 1 YFAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH last birthday) Months Days Haurs White 03-04-92 WIDOWED DIVORCED ony Female the attending physician and sit permit. Then please rem 10a. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) 1Db. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life even if retired)
Housewife COUNTRY? U.S.A. AT HOME Maryland, Baltimore 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removo Morris Jacobs Marv 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Med. Record (Yes, na, arunknawn) (If yes give war or dates of service) 220-54-667101 Springfield Hospital, Sykesville, Md. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN signed by the burial-transit p PART I. DEATH WAS CAUSED BY ONSET AND DEATH Cardiac failure IMMEDIATE CAUSE (o). days DUE TO Metastatic carcinoma of the liver due to Conditions, if any, which gave years rise to immediate cause (a), DUE TO Old breast cancer stating the underlying cause Page 4 may be retained by the hospital or attending TO FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached for use as the should be filed with the State Dept. of Health prior to be last. years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? Schizophrenic Reaction. Paranoid type. NO 2Dg. ACCIDENT WAS LINDERLYING [7] 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Day, Year 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Hame, farm, (City or tawn) (County) (State) Haur o.m. factory, street, affice bldg., etc.) Nat While at wark at wark 21. I certify that *\() (this haspital) attended the deceased from 6-25-29 1967, that 4) (we) last 4-27 . 19 . ta saw the deceased alive an April 27 19 67, and that death accurred at 11:45 M, fram causes and an the date stated above 22a. SIGNATURE 22b. DATE SIGNED ATTENDING STAFF PHYS. G DIRECTOR 4-27-67 M.D. 22d, ADDRESS 22c. PHYSICIAN'S Naci Buyukunsal. M.D. NAME (Type) Springfield Hospital. Sykesville, Md. 23d. LOCATION (City or Town) 23a. BURIAL, CREMATION, 23h. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) REMOVAL (Specify) BALTIMORE, MARYLAND OHEB SHALOM 4/28/67 24. FUNERAL DIRECTOR ADDRESS 2So. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) SOL LEVINSON & BROS. INC., 6010 REIST., RD. 20 M 1/66 DATELAY Mineta, Judge

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where decressed lived, If institution: Residence before admission) a. COUNTY e. STATE b. COUNTY MARYLAND Carroll Maryland b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL and give nearest town) write RURAL and give nearest town) Westminster
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give streat address) d. STREET ADDRESS a. IS RESIDENCE ON A FARM? YES NO. W. Green St. Middla DECEASED (Type or print) 19 67 CORRIN 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 9. AGE (In years | IF UNDER 1 YEAR 8. DATE OF BIRTH IF UNDER 24 HRS. last birthday) pue Months Devs Male WIDOWED A DIVORCED 10a. USUAL OCCUPATION (Giva kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11, BIRTHPLACE (County & State, or foraign country) 1 12. CITIZEN OF WHAT COUNTRY? dona during most of working life, even if retired) Carroll Co. Md. Real Estate Broker U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME William L. Corbin Florence Yingling 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT (Yes, no, or unkown) | (If yes give war or dates of service) 18. CAUSE OF DEATH Enter only one causa pecline for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave risa to immediata cause (a), stating the undarlying PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1101 19. WAS AUTOPSY PERFORMED? NO Z 200. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter paters of injury in Port I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICA 20c. TIME OF INJURY 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (County) (State) Month, Day, Year 20f. (City or town) factory, street, office bldg., atc.) No While Whila Hour e.m. at work at work 21. I certify that (I) (this hospital) attended the deceased from. and that death occurred at... M, from the causes and on the date stated above.196 saw the deceased alive on.... 22b. DATE 22a. SIGNATURE ATTENDING STAFF SIGNED PHYS. DIRECTOR 22d. ADDRESS 22. PHYSICIAN'S NAME (Typa) Saffel Main St. Reisterstown, Md. 23a, SURIAL, CREMATION, 23b. DATE THEREOF 23d. LOCATION (City, town or county) 23c. NAME OF CEMETERY OR CREMATORY REMOVAL (Spacify) O To 967 Burial Meadow Branch Carroll Co. Md. 24 FUNERAL DIRECTOR'S SIGNATURE 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4

MARYLAND STATE DEPARTMENT OF HEALTH

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before edmission) b. COUNTY MARYLAND outside corporete limits, write RURAL and give neerest town) c. LENGTH OF STAY IN 16 OR TOWN (if outside corporate limits, þ Ξ NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address . IS RESIDENCE ON A FARM? YES NO mpletely 3. NAME OF Middle Month Dev Yeer DECEASED (Type or print) DEATH 196 and c B. DATE OF BIRTH 5. SEX AGE (In years | IF UNDER I YEAR IF UNDER 24 HRS. MARRIED NEVER MARRIED last birthday) Months Deys WIDOWED Z DIVORCED physician USUAL OCCUPATION (Give kind of work 12. CITIZEN OF WHAT COUNTRY? 10b. KIND OF BUSINESS OR INDUSTRY BIRTHFLACE (County & State, or foreign country) during most of working life, eyen if retired) 13. FATHER'S NAME ARMED FORCES SECURITY NO. no, or unkown) | (If yes give wer or dates of service) 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Some yeurs IMMEDIATE CAUSE (e) DUE TO gave rise to immedieta cause DUE TO (a), stating the underlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT WAS AUTOPSY CERTIFICATION PERFORMED? NO Z 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Pert II of item 18.) 20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, ferm, 20f. (City or town) (County) (State) 20c. TIME OF INJURY Month, Dey, Yeer fectory, street, office bldg., etc. Not While While Hour a.m. et work et work 1967, to CAR. 54, 1967, that (1) (we) last 21. I certify that (1) (this hospital) attended the deceased from head to 24 " saw the deceased alive on ... 22b. DATE 22e. SIGNATURE SIGNED ATTENDING DIRECTOR PHYS. FUNERAL 22d. ADDRESS 22c PHYSICIAN'S NAME (Type director, be filed 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City. 23a. BURIAL, CREMATION. OI PREC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 15M 7/61

RYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 04975 CERTIFICATE OF DEATH PLACE OF DEATH PLACE OF DEATH

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1. PLACE OF DEATH a. COUNTY	2.	USUAL RESIDENCE (Where deco		sidence before admission)
CARROLL	MARYLAND	a. STATE POULANT	b. COUNTY	20011
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		CITY OR TOWN (If outside corp	orate ilmits, write RURAL	end give nearest town)
WESTMINISTER RATEU	SOYRS.	VI CTONINICTS	ED DAH	11 01 1
d. NAME OF HOSPITAL OR INSTITUTION (if not in ho	spital, give street address) d. 3	STREET ADDRESS	K NAM	0. IS RESIDENCE
ROUTE	140	POUT	= 140	ON A FARM?
3. NAME OF First	Middle	700076	Month	YES NO Day Year
OECEASED (Type or print) LAURA BUR	NETTE DRE	CHSLER 0F DEATH	APRIL	20 1967
5. SEX 6. COLOR OR RACE 7. MARRIED	NEVER MARRIED 8. DA	ATE OF BIRTH 9.		YEAR IF UNDER 24 HRS
FEMALE WHITE WIDOWED	DIVORCED 7	8.6.1886	yrs. Months	Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done 1Db. Kil during, most of working life, even if retired) IN	ND OF BUSINESS OR 11 DUSTRY	. BIRTHPLACE (County & State,	or foreign country) 12, CI	TIZEN OF WHAT
HOUGE-WIFE	JOSIKI /	MARULANI		1
13. FATHER'S NAME	14.	MOTHER'S MAIDEN NAME		0-4
JOHN G. ELY		BERTHA	BOLTE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. S (Yes, no, or unkown) (If yes give war or dates of service)	OCIAL SECURITY NO. 17. INFO	RMANT	Address S.	AME
(11 yes give war or dates of service)	LES	TER E. DREC	HSLER AD	PRESS
18. CAUSE DF DEATH [Enter only one cause per lin	e for (a), (b), and (c),]	1/	-	INTERVAL BETWEEN
PART I. DEATH WAS CAUSED BY:	Thomas of	Hortde	20000	ONSET AND DEATH
IMMEDIATE CAUSE (a)	wy war	Town Out	and a	10+grz
Conditions, if any, which)				
gave rise to Immediate	FULL TELESCOPE			
underlying course lock				
	ING TO DEATH BUT NOT RELATED T	TO THE TERMINAL DISEASE COND	ITION GIVEN IN PART 1(a)	119. WAS AUTOPSY
PARTH OTHER SIGNIFICANT CONDITIONS CONTRIBUTED 2Da. ACCIDENT WAS UNDERLYING 2Db. DI OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	with for	- 1 +		PERFORMED?
2Da. ACCIDENTI WAS UNDERLYING 17 1 2Db. DI	ESCRIBE HOW INJURY OCCURRED	(Enter nature of Injury In Par	t I or Part II of Item 18	
OR CONTRIBUTING TO CAUSE OF DEATH	SOME HOW HOOK! GOOKKED	. (Linter nature of mjar) in rai	t for fait if of itom 20.	
	JURY OCCURRED 2De. PLACE OF	FINJURY (Home, farm, 2Df. (City or town) (Cou	nty) (State)
2Dc. TIME OF INJURY Month, Day, Year 2Dd. IN Hour a.m. While at work		reet, office bldg., etc.)	City or town) (Cou	ity) (State)
p.m. 19 at work				
21. I certify that (I) (this hospital) attended		957, 19 tol		that (I) (we) last
saw the deceased alive on Con-	1919.67, and that dear	th occurred at 335 M, fro		
22a. SIGNATURE	A. A.	TTENDING - MED.	STAFF 22b. DA	TE SIGNED
22c. PHYSICIAN'S	YUM M.D. PI	HYS. DIRECTOR L	PHYS.	120/67
NAME (Type)	NC	LOSS DONESS	RIM Westn	unster mi
23a. BURIAL, CREMATION, 23b. DATE THEREOF	23c. NAME OF CEMETERY OR C	CREMATORY / 1 23d. LOC	ATION (City, town or cou	nty) (State)
REMOVAL (Specify)	FIEDENET	MEM PORTAL	TIMIKA	IDL DOMA
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGIS	TAR 25b. RECESTRAR	SIGNATURA
Q- 6.32 . O. 14	1 tours to 2	ADD 2 1	1967 Julian	A June
1 2 Mislor P. M	11 mountes	DATE AT IN A 4		0

VR A15 (4) 20M 1/65

STEED TO THE PARTY OF THE PARTY And the MARKERND CARROLL 2108842 HESTMINISTER ROBY SOYAS MESTAMMSTER, ROEY 1001 E 140 140 ... LAURIA BURNETTE PRECHEUER APRIL 20 67 FEMALE WHITE ~ 371HM 3MMET HOUSE-HIFE - MARYLAND U.S.O. JOHN G. ELY BERTHA BOLTE SAME LESTER E. DRYCHSLER, DOMESS

BURGARY & PELLET EVERGEREN MEN-GARDENS FINKSBURG RIJED.

<u>1</u>		MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAR'	YI AND
FOR ST		04976 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	Anne
HEALTH	DEPT.	1. PLACE DF DEATH a. COUNTY a. COUNTY a. COUNTY	dence perore admission)
1 Val		CARROLL MARYLAND CA	PROLL
funeral may be	Department after death.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	d give nearest town)
the fund 5 may	Per	UNIONTOWN MINUTES UNIONTOWN	16-1
lay is 3 to the Page 5	atte)	d. NAME OF HOSPITAL OR INSTITUTION (If not In hospital, give street address) d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
	State hours	3. NAME DF First Middle Last 4. DATE Month	Day Year
M3	the 72	OF (Type or print) STERLING RAY ECKER DEATH APRIL	1 1967
= 1 =	2 with within		YEAR IF UNDER 24 HRS.
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ive P	1 and event		ZEN OF WHAT NTRY?
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m 1 m 1 se a	in in	STERLING ECKER FLORENCE STRINE	
24 h n Ite Offic	File, and	15. WAS DECEASED EVER IN U.S. ARMED FDRCES? 16. SDCIAL SECURITY ND. 17. INFORMANT (Yes, no, or unknown) ((f yes give war or dates of service)	
thin icil i	permit. removal,	NO 219-09-6245 ILENE ECKER UNIONTOWN	1 MD
d wir	геп	18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c). 1 PART I, DEATH WAS CAUSED BY:	INTERVAL BETWEEN ONSET AND DEATH
g" ir	cremation, or	012 IMMEDIATE GAUSE (a)	wady
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d be ped ", pe	buri crem	gave rise to immediate (cause (a), stating the DUE TO	
shou vord Chief		underlying cause last.) (c)	119. WAS AUTOPSY
he v	used as to burial	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL OISEASE CONDITION GIVEN IN PART 1(a) 20a. EXTERNAL CAUSE WAS PRIMARY TAO CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE FROW INJURY OCCURRED. NEGRES nature of Injury in Part 1 of Part 10 of Item 12.	PERFORMED?
ntific ng t l to	or to	20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED NEATER nature of July In Part 1 pt Part 1/0f Item 123	2 0
s ce writi ardec	, pri		ence
MEDICAL MAMINER: This certificate should be executed within 24 hours after death. If secute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form or your files.	3 should be agent, prior	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF MJURY (Home, farm, factory, street, office bidg., etc.) 20f. (City or town) (Count factory, street, office bidg., etc.) 20f. (City or town) (Count factory, street, office bidg., etc.)	(State)
INER iffica be f	ed a		of The
cerr cerr ould	its designated	21. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, death resulted from: Natural causes Accident Suicide Homicide Undetermined manner	and in my opinion
the the	desi	death resulted from: Matural causes Accident X, Suicide, Homicide, Undetermined manner	
execute Page		SIGNATURE MEDICAL EXAMINER [22, DATE SIGNED
_ × × −	FUNERAL DI f Health or	EXAMINER'S MI CITAIN SPEINHER STORY MEDICAL EXAMINER X	of Caria
DEPUT please director retained	Heal	NAME (Type) // CTLE/VIII SELECTION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or count	ty) (State)
ple dir ret	20	BIRIAL 4/4/67 PIPE CREEK CARROLL CU	mD
\$4m.	M	24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b APGISTRAR'S	SIGNATURE
VR A1 3500		DD Hartzler Y Sons New Windson, My DATEPR 4 1961 June	0

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND DEATH CERTIFICATE OF funeral and 2 death. PLACE DE DEATH USUAL RESIDENCE (Where deceased lived, If institution: Res a. COUNTY b. COUNTY MARYI AND b. CITY OR TOWN (if outside corporate limits, c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b write BURAL and give nearest town) Ξ e. IS RESIDENCE ON A FARM? ve carbon papers. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS filled YES NO executed within completely DATE DF DEATH Day Year NAME OF Middle 4. Last DECEASED (Type or print) 19/2 AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. last birthday) | Months | Days | Hours | Min. SEX 6. COLOR OR RACE DATE OF BIRTH NEVER MARRIED 7. MARRIED remove any and WIDOWED [DIVORCED [12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR INDUSTRY 10a. USUAL OCCUPATION (Give kind of work done) 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) COUNTRY? pe PRKER FATHER'S NAME death certificate 14. attending pr remova 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT 17. transit permit, cremation, or r (Yes, no. or unkown) (If yes give war or dates of service) the CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). The law requires that the al-transit à PART I. DEATH WAS CAUSED BY: physician. IMMEDIATE CAUSE (a) been signed burial-ti burial, DUE TO Conditions, If any, which rise to immediate attending the r to DUE TO (a), stating prior underlying cause last. as WAS AUTOPSY PERFORMED? CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) r this certificate h detached for use te Dept. of Health for use Health NO T YES [PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part 1 or Part 11 of Item 18.) OR CONTRIBUTING | CAUSE OF DEATH be detacher State Dept. (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL (State) 20d. INJURY OCCURRED 120e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) 20c, TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) After tould be the state of the Hour a.m. Not While While ATTENDING m.g at work at work 21. I certify that (i) (this hoppital) attended the deceased from DIRECTOR: age 3 should lied with the and that death occurred at 5 M, from the causes and on the date stated above. saw the deceased alive on DATE SIGNED ATTENDING PHYS. STAFF page M.D. DIRECTOR director, pag should be fill O HOSPITAL ADDRESS 23d. LOCATION (City, town or county) DATE THEREOF CEMETERY OR CREMATURY CREMATION. 23b. 23c. 23a. REMOVAL (Specify) D BY REGISTRAR REGISTRAR'S SIGNA FUNERAL DIRECTOR A15 (4) 20M

CARROLL MARYUND CARROLL WESTHINSTER DOA, WESTHINSTER ND EARBOLL CO. G. EN. 140SP 154 PENNY AVE LEVERE LEWIS ESSOM APR 2 67 MALE WHITE Su-14, 1911 56 WORKER, MENT PACHUG PLANT WESTALINGTER, MD U.S.A. CHARLES WM- ESSOM FLORENCE LOATS SAME YES WHIT 219-01-4512 AMS FLURENCE L. ESSON, RODRESS ACUTE MYSCERZDIBL INFARCTION -CORONARY ARTERY DISEASE I YEAR ACTERNSLLEROTIC CHRANDSWIND DIS 2 YEM

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W. PRESTON STREET, BALTIMORE 1, MARYLAND OF DEATH TIFICATE 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where dacessed lived, If Institution: Rasidence before edmission) a. COUNTY b. COUNTY MARYLAND h. CITY OR TOWN (if outside corporate limits c. LENGTH OF STAY IN 16 OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO NO Stree Main completely NAME OF 4. DATE Month Dev Yaa DECEASED OF (Type or print) DEATH 196 carbon 5. SEX DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED T NEVER MARRIED T last birthday) and Months Hours WIDOWED 1 DIVORCED USUAL OCCUPATION (Give kind of work physician 10b. KIND OF BUSINESS OR INDUSTRY | 11. 12. CITIZEN OF WHAT COUNTRY? foreign country) done during most of working life, even if retired) Torise 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAM please 2 affending 15. WAS DECEASED EYER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMA (Yes, no, or unkown) | (Ifyes give wer or dates of service) affending physician. as been signed by the 18. CAUSE OF DEATH [Enter only one cause par line for (a), (b), end (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which (b) gave rise to immadiata cause DUE TO (a), stating the underlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 1 19. WAS AUTOPSY PERFORMED? 0 NO 4 20a. ACCIDENT WAS UNDERLYING TI 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Homa, farm. 20f. (City or town) (County) (Stata) factory, streat, offica bldg., atc.) Hour a.m. Whila Not Whila at work at work p.m. 21. | certify that (1) (this hospital) attended the deceased from ARMA, 19,0%, that/(I)/(we) last 6.7., and that death occurred aleas M from the causes and on the date stated above. saw the deceased alive on 22a. SIGNATURE DATE ATTENDING SIGNED DIRECTOR PHYS. M.D. death. Page 4 O FUNERAL 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) 23a. BURIAL, CREMATION, | 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (Stata) REMOVAL (Spacify) OH Sandymount Cemetery Sandymount. Carroll Co. Md. 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A1S pton - Eline Funeral Home Hampstead. Md.

MARYLAND STATE DEPARTMENT OF HEALTH - Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04979 CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o COUNTY o. STATE Carroll Maryland MARYIAND law requires that the deoth certificate be executed within 24 hours often b. CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 write RURAL and give nearest town) in by 1 Month Rural-Woodbine Westminster d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? R.D. Carroll Co. General Hospital YES NO IX 3. NAME OF First Middle Lost 4 DATE Month Doy Year DECEASED ROSE F. FIFMING 3 196 Type or print DEATH S. SEX 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH birthdoy) Doys Hours Female White Sent. 6.1912 dny WIDOWED DIVORCED ond 10o. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) physician c during most of working life, even if retired)
HOUSEWIIE INDUSTRY COUNTRY 3 Baltimore City. Md. J. S. A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remaval Joseph Swiston Pauline by the ottending parameter there 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address (Yes, no, or unknown) (If yes give wor or dotes of service) a 16-03-2766 Mr. Raymond O. Fleming Same As cremotion, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the buriol-transit IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse the hospital or ottending the hos been lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) WAS AUTOPSY PERFORMED? O FUNERAL DIRECTOR: After this certificate YES | NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Dov. Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m Not While foctory, street, office bldg., etc.) of work at work Page 4 may be retained by 21. I certify that (1) (this hospital) attended the deceased from 3/27 13, 1967, that (1) (we) last . 1967 to 4/13 1967, and that death occurred at 7 20 M, from couses and on the date stated above saw the deceased alive on. 220. SIGNATURE 22b. DATE SIGNED ATTENDING STAFF PHYS. M.D. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Fiocco Vincent Westminster. J. director, should 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) BURIAL CREMATION. (Stote) REMOVAL (Specify) Morgan Chanel Carroll 24. FUNERAL DIRECTOR **ADDRESS** 2So. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) M. Waltz Box 241 Sykesville, Md. 20 M 1/66

death certificate be executed

ARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYI

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4_ 1		MARYLAND STATE DEPARTMENT OF HEALTH
FOR		Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
TUK 3	DEPT.	04981 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04981
HEALIH	DEP1.	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE DADVIA IND. COUNTY ARREST
~= 0	ی ب	CARROLL MARYLAND MARYLAND CARROLL
the funeral 5 may be	eath	b. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town) write RURAL and give nearest town)
scessal e funer may	er d	WESTMINSTER DOF UNION BRIDGE
5 th	De afte	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
Page Page	State Department hours after death.	DOA CARROLL CO GENERAL HOSPITAL 205 MAIN ST YES NOW
and del	S Pho	3. NAME OF First Middle Last 4. DATE Month Day Year DECEASED OF OF OR OT OT OF OR OT
PM,	****	(Type or print) KI (HAKI) LEKOV TOKNEY DEATH HAKIL - 14-1961
S1,	with with	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Doys Hours Min.
age 1 to	# 2 m	WIDOWED DIVORCED DEC 16-1941 25 yrs.
ve F	l and event	during most of working life, even if retired) INDUSTRY COUNTRY?
afte Gi	iny e	MACHINE OPERATOR CONSTRUCTION MARYLAND USA
ars arc	pages 1 in any	13. FATHER'S NAME CLAUDE E FORNEY EDITH REESE
hortem	File	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address
in 124	. in	(Yes, no, or unkown) [(If yes give war or dates of service)]
in i	permit. I removal,	118. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), 1
AL EXAMINER: This certificate should be executed within 24 hours after death. If any delathe certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and should be forwarded to the Chief Medical Examiner's Office along with form PM3.	rei	PART I. DEATH WAS CAUSED BY:
a series	burial-transit cremation, or	IMMEDIATE CAUSE (a) PARAMETER CRITICAL DESIGNATION OF THE PARAMETER CR
ding	burial-trans cremation,	Conditions, If any, which \ (b) Shulling 11 + Multiple Body
ben	uria	gave rise to immediate
onld ief !	a b	underlying cause last. (c)
S S S S	used as a to burial,	(V) Iso Man all Today
the	o pi	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) PERFORMED? YES NO 20a. EXTERNAL CAUSE WAS PRIMARY BY OF CONTRIBUTING THE CAUSE OF DEATH. CAUSE OF DEATH. PERFORMED? YES NO CAUSE OF DEATH.
The state of the s	or t	20a. EXTERNAL CAUSE WAS PRIMARY TO OF CONTRIBUTING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II of Part II of Item 18.) FELLOW FOR SUPPLY SUPPLY CONTRIBUTIONS FELLOW FOR SUPPLY SUPPLY CONTRIBUTIONS FELLOW FOR SUPPLY SUPPLY CONTRIBUTIONS FELLOW FOR SUPPLY
rdec rdec	plu	CAUSE OF DEATH. Fellow fof Trees sounding Cierch Court of Cierch Court o
This wa	3 should be agent, prior t	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED, 20e. PLACE OF INJURY (Home, farm,), 20f. (City or town) (State)
icatie fo	8 D 1/2	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED, 120e. PLACE OF INJURY (Home, farm, 20f. (City or town) Hour Hour 4-14/ 196/ at work A Howk Holl Kell Curron Bridge Carroll Mile
db	R: Page	21. I certify that I took charge of the remains described above, held an Autopsy, Inspection X, Inquiry, and in my opinion
T S S S S S S S S S S S S S S S S S S S	rok: lesign	death resulted from: Matural causes , Accident , Suicide , Homloide , Undetermined manner
3 4 3	our mes birector: r its design	CHIEF MEDICAL EXAMINER
ry MEDICA execute t Page 4	DIRECT Tits d	ACTUAL SIGNATURE M.D. ASSISTANT MEDICAL EXAMINER 22. DATE SIGNED
	AL D	EXAMINER'S AND PITINGS DE LOUIS DE LA SECONOMINER X
Pur	NER ealt	NAME (Type) / V GLENN STETCHEN Address (Street, Party, Loung, or Editor)
O DEPUTY please ex director.	To FUNERAL R of Health or	- RFMOVAL (Specify)
1	= 0	24 FUNERAL DIRECTOR ADDRESS 1,25a, RECID BY REGISTRAR 25b, REGISTRAR'S SIGNATURE
VR	A15ME	10 10 Hartsley Jana Union Bridge Ma DATE 18 1967 goliantes Judge
	0 4-64	NN Manden A Doug Anne Mineral Principal Marie

MAKYLAND STATE DEPARTMENT OF HEALTH

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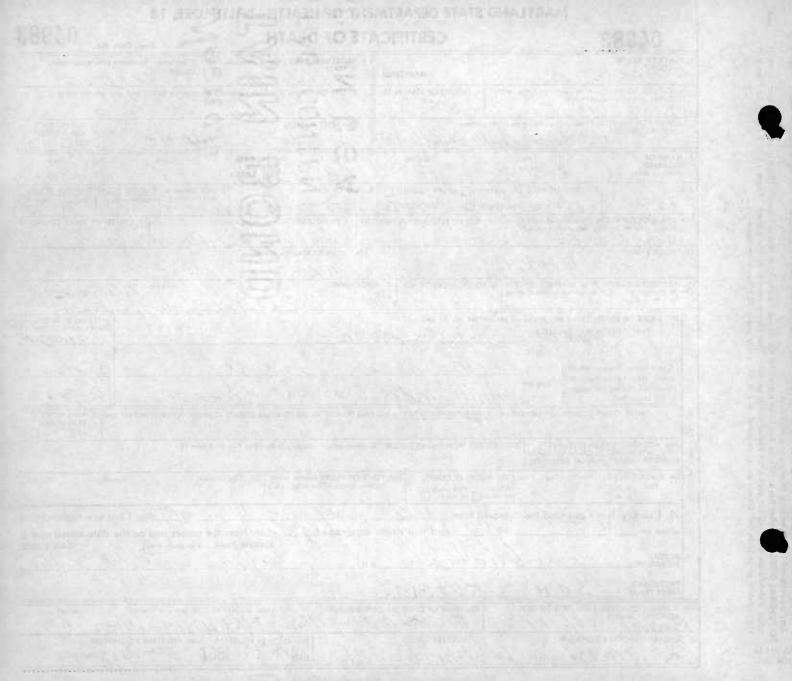
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4983	CERTIFICATE OF DEAT
3000	

Reg. Dist. No.

04983

	1. PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)						
	O. COUNTY ARROLL MARYLAND	O. STATE B. COUNTY CAPPALL						
	b. CITY OR TOWN (If autside carporate limits, write c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn)						
1	RURAL and give nearest town) SUKF SUKF = 3 MD.	WESTMINISTER 16.1						
	d. NAME OF HOSPITAL (If not in hospital, give street oddress)	d. STREET ADDRESS e. IS RESIDENCE						
	OR INSTITUTION PULLEN NURSING HOME	COR. MAIN AND BOND STS. ON A FARM?						
	3. NAME OF A First Middle							
	DECEASED (Type or print) Mary)/ I/A = C OF						
	1 0.	B. DATE OF BIRTH 9. AGE (In yedrs IF UNDER 1 YEAR) IF UNDER 24 HRS.						
1	FEMALE INHITE WIDOWED DIVORCED	CIPT 10 10 17 last birthday) Months Days Hours Min.						
/	10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDU:	STEV 11 PROTUBLISTS (State or fresion greater) 12 CIVITEN OF WALL COUNTRIES						
	during mast at working life, even if refired)	STRY 11. BIRTHPLACE (State or foreign country)						
	13. FATHER'S NAME	[4]RROLL (0.111). 43.0.						
ı	JOHN BARNES	14. MOTHER'S MAIDEN NAME						
ı	V 01110 / 1	MARTHA HOOR						
	IVes no as unknown) . Iff we simple of the last	NFORMANT Address E.G.RTENST.						
		RS. S. HERBERT YINGLING WESTMINSTER						
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN A						
4	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (0) Anen more	na 3 days						
	DUE TO Y	1/197						
1	Conditions, if any, which) (b) Chy, hea	est Say lure 5 ms.						
	gave rise to immediate couse (a), stating the under-							
	lying couse last. (c) HARRY OSECULANE (, VICUSEASE (C) 725							
,	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED?						
		YES NO						
1	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT 200. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED OR CONTRIBUTING CAUSE OF DEATH III FEITHER, NOTIFY MEDICAL EXAMINER	D. (Enter nature of injury in Part I or Part II of item 18.)						
П								
		ACE OF INJURY (Home, farm., 20f. (City ar tawn) (Caunty) (State) tary, street, office bldg., etc.)						
	Hour o.m. Hour o.m. 19 While Not while fac	dury, sireer, office orage, etc.)						
	21. I certify that I attended the deceased from/_/							
	1	The deceased						
	, individual and their dealth	Occurred at 7 M, from the causes and an the date stated abave. ADDRESS (Street, city or town, state) DATE SIGNED						
	SIGNATURE Sam Muyman	Carlocullo MA 4 116						
d	0 1011	W.D.						
1	PHYSICIAN'S Sani Ukutman							
	220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OF	CREMATORY 22d. LOCATION (City, town, or county) (State)						
	Burnel 4/14/67 MT, PLEAS	ANTCEM. FINKSBURG ROHZ MD						
	3. EUNERAL DIRECTOR'S SIGNATURE ADDRESS	24g. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE						
-	*2. meso p. Westmuder	Mr. DARTH 17 1967 Schanles Judge						
-								



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04984 FOR STATE HEALTH DEPT. 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission PLACE OF DEATH CARROLL a. STATE b. COUNTY delay is and 3 to 3. Page Pennsylvania MARYLAND CITY OR TOWN (If outside corporate limits, write RURAL and give neorest tawn) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b WESTMINISTER Shippensburg d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) d STREET ADDRESS with the State Dep Office alang with farm 60 36 West King Street CARROLL COUNTY GENERAL HOSPITAL 8. Give Pages haurs after death. NAME OF First Middle Lost 4. DATE Month Doy DECEASED 25 WAYNE Franklin HAMMOND DEATH (Type or print) IF UNDER 1 YEAR 6. COLOR OR RACE 7. MARRIED IX NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years Jaly 26, 1907 lost birthdoy) Months White WIDOWED DIVORCED Male Item] within 72 hours after death File pages land2 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired)
Os topa th INDUSTRY COUNTRY? Spring Run. Pa. 24 shauld be farwarded to the Chief Medical Examiner's .= pencil 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME be executed within Franklin Wolff Martin Hammond Mary Ann .= IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service Mrs. Emma Hammond same address INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: burial-transit ONSET AND DEATH event Arteriosclerotic cardiovascular disease IMMEDIATE CAUSE (o) This certificate shauld writing the ward 4221 DUE TO in any Conditions, if ony, which gove rise to immediate couse (a). DUE TO 0 stoting the underlying cause and be used PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) crematian, or remaval, YES X execute the certificate, 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of item 18.) 3 should PRIMARY Or CONTRIBUTING MEDICAL EXAMINER: CAUSE OF DEATH. MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (County) Hour o.m. Not While foctory, street, office bldg., etc.) FUNERAL DIRECTOR: Page of work ot work 21. I certify that I taak charge of the remains described above, held an Autapsy [X], Inspection Inquiry and in my apinian burial, death resulted fram: Natural causes XX Accident Suicide [Hamicide Undetermined manner funeral directar. may be retained CHIEF MEDICAL EXAMINER Health priar ta ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER 4-25-67 WERNER U. SPITZ M.D. NAME (Type) Address (Street, city, town, or county) 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY Shippensburg, 4/29/1967 25o. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE

VR A15ME (5) 6M 1/67

IS RESIDENCE

ON A FARM?

YES

NO NO

Year

1967

IF LINDER 24 HRS

Hours

WAS AUTOPSY PERFORMED?

NO

(Stote)

22. DATE SIGNED

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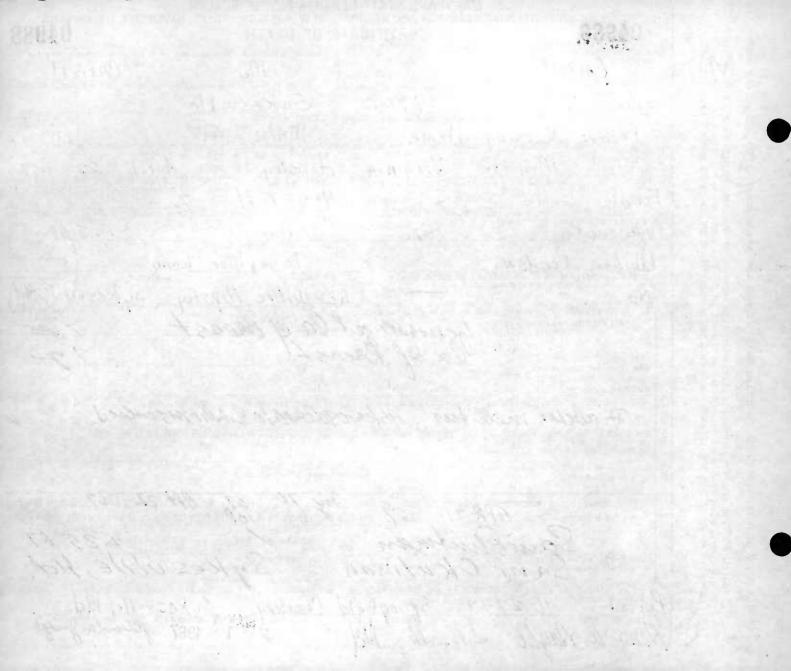
	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MA	RYLAND
	04985 CERTIFICATE OF DEATH	04985
1.	PLACE OF DEATH a. COUNTY Carroll AMARYLANO 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence as STATE Maryland b. COUNTY Carr	dence before admission)
	b. CITY OR TOWN (If outside corporate limits, write RURAL an write RURAL and give negret fown)	nd give nearest town)
	Finksburg #2 30 YRJ. Finksburg #2	
	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kay's Mill Road Kay's Mill Road	e. IS RESIDENCE ON A FARM? YES NO A
3.	NAME OF First Middle Last 4. DATE Month OF OF A COLUMN OF THE ORIGINAL	Oay Year
5.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. OATE OF BIRTH 9. AGE (In years IFUNOER 1)	YEAR IF UNOER 24 HRS
	emale white widowed Divorceo Aug 2, 189/ 75 yrs. Months Of	ays Hours Min.
10 du	uring most of working life, even if retired) INDUSTRY COU	IZEN OF WHAT NTRY?
3.5	housewife Baltimore U.S 3. FATHER'S NAME	.A.
1.	Harasha Nelson Justice Carrie E. Hardyshell	
1 (Y	15. WAS OECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Yes, no, or unknown) (If yes give war or dates of service) 2/2/1/20/1/2/484 Howard 7. Hansen	in RD#/
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION	INTERVAL BETWEEN ONSET AND OEATH 2 - 3 M/A
	Conditions, if any, which gave rise to immediate cause (a), stating the OUE TO OUE TO (b) ALTERIOS CLERS TIC CARDIOVASCULAR DISEASE DUE TO	3 Mes
ATION	underlying cause last. (c)	19. WAS AUTOPSY PERFORMEO?
CERTIFICATION	20a. ACCIDENT WAS UNDERLYING TO COURTED. (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF OEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
MEDICAL	20c. TIME OF INJURY Month, Oay, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (Count factory, street, office bldg., etc.) 20f. (City or town) 20f. (City or tow	ty) (State)
	21. I certify that (I) (this hospital) attended the deceased from SPT, 1977, to JAN 11, 1967, saw the deceased alive on JAN 11, 1967, and that death occurred at 32 M, from the causes and on the	
	William J. Stewart M.D. ATTENDING MED. STAFF HYS. 4/1	11/67
25	NAME (Type)	ity) (State)
	burial April 14/67 Sandymount Cemetery Finksburg #1 Ms	ryland
2	24. FUNERAL OIRECTOR & LEST MINISTER, Md. 258. REGISTRAR 256. REGISTRAR'S DAFK 13 1967 Filesnies	Jusqu

BRIS'S TRUCK The state of the s A.S. U p Clestrick of the serven action of the serven actions and the serven actions and the serven actions are serven as a serven action of the serven actions are serven as a serven action of the serven actions are serven as a serven action of the THE RESERVE OF THE PERSON OF STREET OF STREET SHARRANI DE RESEARCH WERE TO THE SHARRANI TO T Casterna, Table 81 MA

MAKTLAND STATE DEPAKTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04986 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission physician and completely filled in by the funeral on please remove corban papers. Pages I and a. COUNTY a. STATE b. COLINTY AFFOL after MARYLAND b. CITY OR TOWN (If autside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) papers. Pag thin 72 hours a write RURAL and give nearest town) d. STREET ADDRESS e. IS RESIDENCE (If not in haspital, give street address) ON A FARM? Minera KOAd YES NO X NAME OF 4. DATE Manth Year DECEASED OF DEATH Arence DINE (Type or print) 19 67 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthday) Manths Days Hours WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) COUNTRY? **INDUSTRY** puo MACHANIC 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME the attending physical research WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMAN 16 SOCIAL SECURITY NO (Yes, no, prunknown) (If yes give war ar dates of service 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) buriol-tronsit PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO burial, Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying couse the hos been lost. WAS AUTOPS' PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? Chique (nonchitis NO 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) Haur a.m. factory, street, office bldg., etc.) Nat While at work TO FUNERAL DIRECTOR: After be retained by 21. I certify that (1) (this haspital) attended the deceased fram man /7 1965 . 1965, that (1) (we) last ta Clar saw the deceased alive an Chril 3 196, and that death accurred at 9 5 M, fram causes and an the date stated above. 22b. DATE SIGNED 22o. SIGNATURE **ATTENDING** M.D. DIRECTOR PHYS. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S U NAME (Type) director, 23a. BURIAL, CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) REGISTRAR'S SIGNATUR FUNERAL DIRECTOR **ADDRESS**

2 1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND.
FOR STATE	04987 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04987
HEALTH DEPT.	1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) b. COUNTY ARROLL MARYLAND MARYLAND OARROLL
delay is necessary, and 3 to the funeral i. Page 5 may be state Department hours after death.	b. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town) WHANCHESTER RATH IN TELK WEST MINSTER RESTANTANTED RESTAN
Sa to the Page 5 retate Department	d. NAME OF HOSPITAL OR INSTITUTION (If not in Hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO
PMS AND	3. NAME OF DECEASED (Type or print) WILLIAM FSTER HIGGINS 5. SEX 6. COLOR OR RACE 7. MARDIED 3. DATE OF BIRTH 9. AGE (in years IF UNDER 14 PER 15 UNDER 24 HRS
Pages 1, h form , h form , h within	MALE WHITE WIDOWED OIVORCED JUNE 2 1906 60 yrs. Months Days Hours Min.
urs after dea n 18. Give Pa along with pages 1 and in any event	10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR during most of working life, even if retired) 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? BURNSVILLE N.C. 13. FATHER'S NAME
14 hours Item 18 Office al File pag and in	MONLT HIGGINS ANNIE RANDOLPH 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address ACESTOCIAL SECURITY NO. 17. INFORMANT
within 2 pencil in miner's C permit, removal,	(Yes, no, or unkown) (If yes give war or dates of service) \$\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
g" in pe Exami ansit pe n, or re	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Throne for Casulto Sindle
ould be executed rd "pending" in ilef Medical Exar a burial-transit il, cremation, or	Conditions, if any, which gave rise to immediate (b)
ficate should the word o the Chief used as a l to burial, c	underlying cause last. (c)
certificat riting the ded to th old be use prior to t	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL OISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO YES YES NO YES
t: This wate, w forwar forwar should should be agent,	20c. TIME OF INJURY Month, Oay, Year 20d. INJURY OCCURRED Hour a.m. 20f. (City or town) (State) (State)
AL EXAMINET the certificates of should be r files. CTOR: Page	21. I certify that I took charge of the remains described above, held an Autopsy, inspection, inquiry, and in my opinion death resulted from:Natural causes, Accident, Suicide, Homicide, Undetermined manner
EDICA age 4 r your DIREC	ACTUAL SIGNATURE CHIEF MEDICAL EXAMINER DEPUTY DEPUTY MEDICAL EXAMINER DEPUTY D
rase ector aine unit Heal	RAMINER'S NAME (Type)
To Figure 10 Ple	23a. BURIAL, CRÉMATION, 23b. DATE THEREOF. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (state) REMOVAL (Specify) 4/26/67 MANUFESTER BAPTEST 24. FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
VR A15ME 3500 4-64	X2. myes, & Westmislin, My Louter 1 20 1301 1

	04988 CERTIFICATE		1, MARYLAND 04988
after death.	1. PLACE OF DEATH a. COUNTY CAFFOLL MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If Instituti a. STATE b. COUNTY	on: Residence before admission
in by s. Pa	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sylcesuile d'Name of Hospital or Institution (if not in hospital, give street address)	c. CITY OR TOWN (If outside corporate limits, write RI	URAL and give nearest town
24 Zfille appe	Pullen Nursing Home	MAIN' St.	ON A FARM? YES NO Y Day Year
ured within congletely ove carbon p	OFFICE SEX 6. COLOR OFFICE 7. MARRIED NEVER MARRIED 8.	Hipsley OF April	22 1967 NDER 1 YEAR IF UNDER 24 HR
xec emd any	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DIVORCED	7-4-1871 76 yrs.	12. CITIZEN OF WHAT COUNTRY?
cate physi	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	U.S.A.
- e==	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, ng, or unkown) (If yes give war or dates of service)	INFORMANT Address R. Willie Hipstey - Su	Kesville, Md
the the sy the silt small	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).1 PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Jensel Color	'la of breast	INTERVAL BETWEEN ONSET AND DEATH
The law requires that the or attending physician. The las been signed by the use as the burial-transit salth prior to burial, crema	Cenditions, If any, which gave rise to immediate cause (a) extens the DUE TO	esfl.	7. 12-1
	underlying cause last. (c)		11(a) 19. WAS AUTOPSY PERFORMED?
Ho Line	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATE PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATE OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART OF THE	SCEPPLY C CONSULT OF PART I OF PART II OF Ite	m 18.)
HYSI the h this detacl	20c, TIME OF INJURY Month, Day, Year 20d, INJURY OCCURRED 20e, PLAC	E OF INJURY (Home, farm, y, street, office bldg., etc.)	(County) (State)
	21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 4 R 2 1967, and that	death occurred at / M, from the causes and	
y be of the same o	22a. SIGNATURE Sam Sunfundan M.D. 22c. PHYSICIAN'S NAME (Type)	ATTENDING MED. PHYS. DIRECTOR PHYS. 22d. ADDRESS	4. 25. 67
O HOSPITAL OR Page 4 may be O FUNERAL DIR director, page should be filed	NAME (Type) San Wutman 239 BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY REMOVAL (Specify)	^	or county) (State)
M	24. FUNERAL DIRECTOR ADDRESS	MAY 1 1967 Pale	TRAR'S SIGNATURE
VR AI5 (4) 20M 1/65	I rainy w. raught syrewith mai	DATE OF T	U

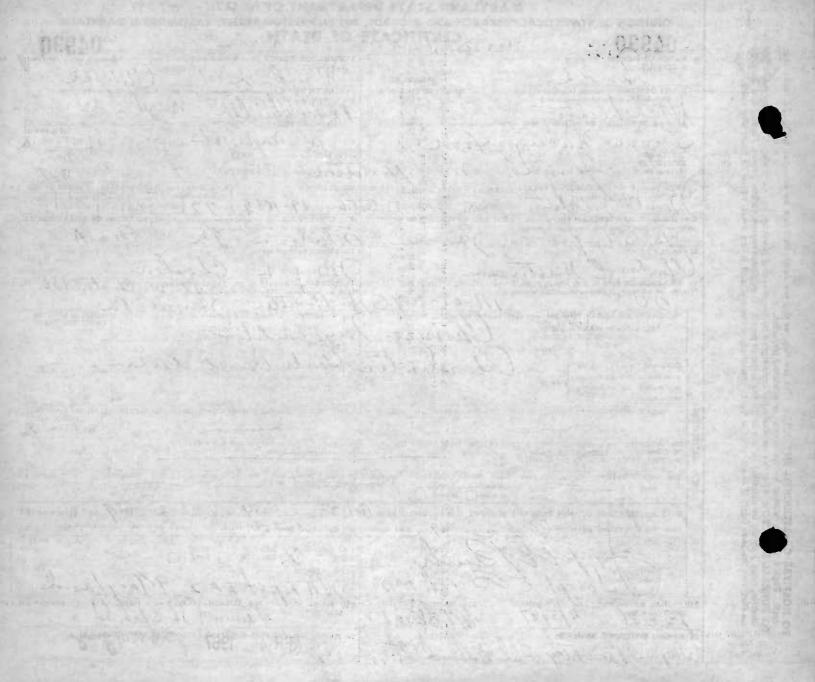


2	1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYL	LAND
	इं करोड़े	0/089 Thom #8 E-CERTIFICATE OF DEATH	989
	executed within 24 hours after death, and completely filled in by the funeral remove orbon papers. Pages 1 and any went, within 72 hours after death.	1. PLACE OF DEATH 2. COUNTY A. COUNTY CATTOI MARYLANO 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence a. STATE D. COUNTY CATTO	21
	ours affi in by the Pages iours af	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. LENCTH OF STAY IN 1b C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sukesvilo	Sville. M
10	thin 24 hours tely filled in by you papers. Pagwithin 72 hours	d NAME OF HOSPITAL OF INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
	vithln related from property f	3. NAME OF PIRST Middle Last 4. DATE Month Oay	
	and comple	(Type or print) //ATTAN C. Hobbs, Jr. DEATH April 3 5. SEX 6. COLOR OR RACE 7 MARRIED NEVER MARRIED 8. DATE OF BIRTH 922 9. ACE (In lears IF UNDER 1 YEAR	
		Male White WIOOWEO DIVORCEO 12-5-1923/ Last birthday) Months Days 10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN	Hours Min.
	icate be e physician n please r val, and in	during most of working life, even if retired) INOUSTRY None Mc	Y?
	death certificate be ne attending physiciar permit. Then please tion, or removal, and i	NATHER'S NAME NATHER'S NAME OF THUSE Shipley	
	e death certifica the attending ph it permit. Then nation, or removal	15. WAS DECEASED EVER IN U.S. ARMED FÜRCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service) Res. Gertrude Hobbs Suke	sville. W
	the don. by the mosit procedure.	PART I DEATH WAS CAUSED BY	ERVAL BETWEEN SET AND DEATH
	ulres that the sphysician. In signed by burial-transit burial, creminal,	4.201 DUE TO Managed in its	/1/67
	The law requires that the or attending physician. sate has been signed by the use as the burial-transit salth prior to burial, crema	gave rise to immediate	/3/67
	HYSICIAN: The law require he hospital or attending this certificate has been letached for use as the b Dept. of Health prior to b	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART 1(a) 19.	WAS AUTOPSY PERFORMEO?
	PHYSICIAN: the hospital this certific detached for e Dept. of H	20a. ACCIDENT WAS UNDERLYING 20b. OESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
		20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at work at work 19 at work 19 at work 19	(State)
	ATTENOING retained by CTOR: Afte should be vith the Sta	21. I certify that (I) (this hospital) attended the deceased from April 1, , 1967, to April 3, 1967, the saw the deceased alive on April 3, 1967, and that death occurred at M, from the causes and on the data	te stated above.
•	y be re OIREC age 3		3, 1967
	O HOSPITAL Page 4 may O FUNERAL (director, pag	PHYSICIAN'S NAME (Type) Howard E. Hall, M.D. 22d. AODRESS Sykesville, Maryland	
	TO HOSPITAL OR ATTENDI Page 4 may be retained TO FUNERAL DIRECTOR: A director, page 3 should should be filed with the	Burial, Cremation, 23b. Oate thereof 23c. Name of cemetery or crematory 23d. Location (city, town or county) Burial (specify) 4-6-67 Springfield Complexy Sykesville,	Mai-
	VR A15 (4)	24. FUNERAL DIRECTOR ADDRESS 25a. RC'O BY REGISTRAR 25b. REGISTRAR'S SICH ADDRESS ADDR	MATURE
	20M 1/65	1 ming with a system way,	

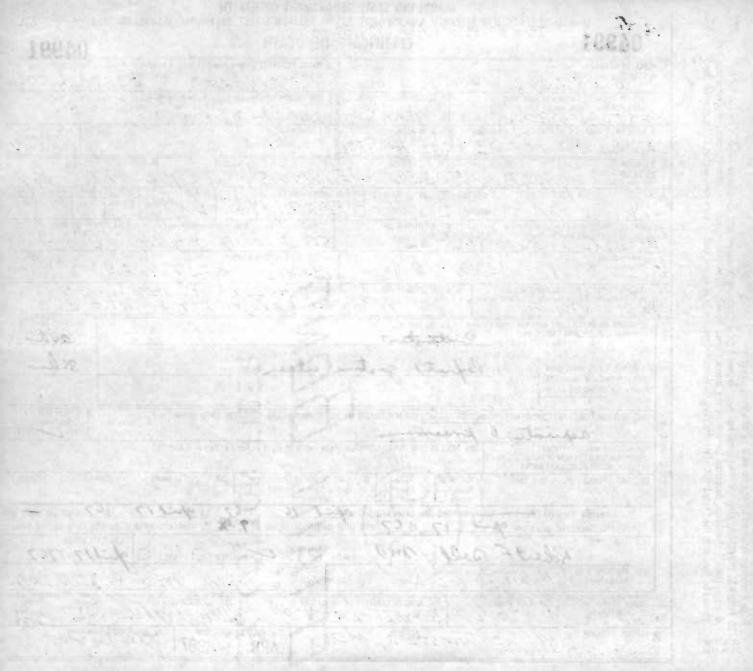
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DIVISION OF STATISTICAL RESEARCH AND RECO 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 2. USUAL RESIDENCE (Where deceased lived, It Institution: Residence before admission) 1. PLACE OF DEATH a. COUNTY MARYLAND b. CITY OR TOWN (if outside corporate fimits, c. LENGTH OF STAY IN 16 TOWN (If outside corporate limits, write RURAL and give nearest town) rite RURAL and giva neagest town) Hanover d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) IS RESIDENCE STREET ADDRESS ON A FARM? 90 YES NO isle papers. n 72 ho NAME OF Middle DATE Month DECEASED OF Type of print) DEATH 196 and comp carbon pa nt, within 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. COLOR OR RACE 7, MARRIED NEVER MARRIED DATE OF BIRTH last birthday) Months Days Hours Min. DIVORCED 10 USUAL OCCUPATION (Give kind of work physician 12. CITIZEN OF WHAT COUNTRY? 10b. KIND OF BUSINESS OR INDUSTRY (County & State, or loreign country) dona during most of working tifa, avan if retired) 13 FATHER'S NAME MOTHER'S MAIDEN NAME attending eld U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. I (Yes, no. or unkown) I (If yas give war or datas of sarvice 18. CAUSE OF DEATH |Enter only one cause per line to INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause DUE TO (a), stating the undarlying causa last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO X 20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of item 18.) 20a, ACCIDENT WAS UNDERLYING | OR CONTRIBUTING LAUSE OF DEATH 20e. PLACE OF INJURY (Homa, farm,) (County) (State) 20c. TIME OF INJURY Month, Day, Year 20d, INJURY OCCURRED 20f. (City or town) factory, street, office bldg., etc.) Not While White Hour a.m. at work at work p.m. 1955 21. I certify that (1) (this hospital) attended the deceased from 1201. 20 19.20, that (I) (we) last M, from the causes and on the date stated above., and that death occurred at 4 deceased alive on. 22b. DATE 22a. SIGNATURE SIGNED ATTENDING A MED DIRECTOR PHYS. M.D. PHYS. **BHYSICIAN** 22c. NAME (T) CEMETERY OR CREMATORY (State) COCATION 23a. BURIAL, CREMATION, 23b. DATE THEREO MOVAL (Specify FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) 15M 7-62

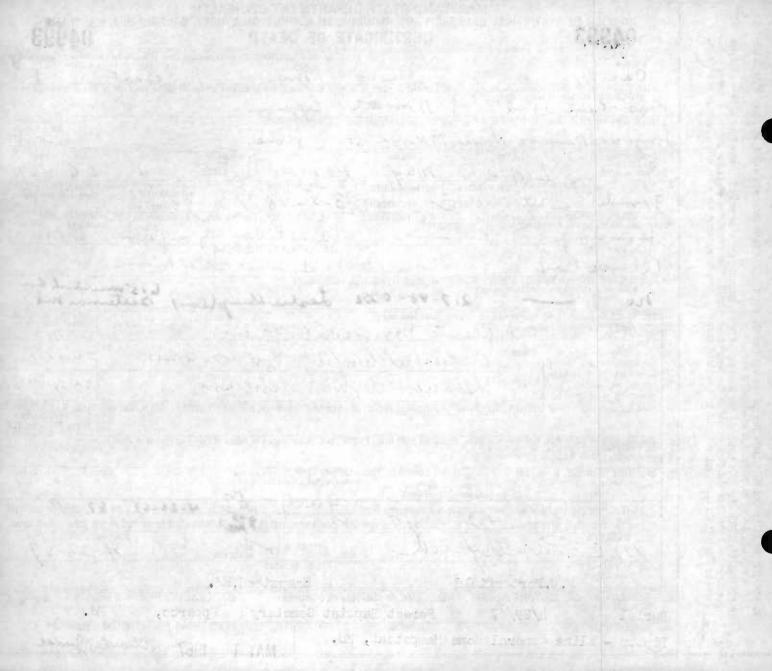
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1 _1	MARYLAND STATE DE Division of STATISTICAL RESEARCH AND RECORDS, 30	PARTMENT OF HEALTH	1201
+	04991 Stem #7 Film #0388 1/25/6	7 nc	0/1001
r deoth.	1. PLACE OF DEATH O. COUNTY MARYLAND	2. USUAL RESIDENCE (Where deceosed lived, if institution: Reside o. STATE ARYLAND)	ence before admission)
certificate be executed within 24 haurs after deoth physician and completely filled in by the funeral then pleose remove corbon popers. Pages 4 and 2 movol, and in any event, within 72 haurs after death	b. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) ### STMINSTER C. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and git	06-1
nin 24 ho filled in l popers. thin 72 ho	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) CARROLL COUNTY GENERAL HOSPITAL	d. STREET ADDRESS RT-41	e. IS RESIDENCE ON A FARM? YES NO
ate be executed with ician and completely f leose remove corbon and in ony event, with	3. NAME DF DECEASED (Type or print) 6. COLDR DR RACE 7. MARRIED	ENNING-5 4. DATE OF DEATH OF DEATH OF DEATH OF APPL 9. AGE (In years IF UNDER	Doy Year 1967 R I YEAR IF UNDER 24 HRS
oe execute and comp remove in ony eve	S. SEX 6. COLDR DR RACE 7. MARRIED WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR	FEB. 21,1925 42 yrs. Months	Doys Hours Min.
erificate be physician a ren pleose i ovol, and in	during most of working life, even if retired)		OUNTRY?
E 9	CREED / JENNINGS 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17.	MAMIE BOATRIGHI INFORMANT HOBELT P. JADDESVILL	NG-S
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thot the ian. I by the transit cremati	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (0) DUE TO DUE TO		ONSET AND DEATH
OR ATTENDING PHYSICIAN: The law requires that the deaple retained by the hospital or attending physician. INECTOR: After this certificate has been signed by the attending should be detached for use as the burial-transit permit. ed with the State Dept. of Health prior to burial, cremation, or residential.	Conditions, if ony, which gove isse to immediate couse (o), stoting the underlying couse	e ulea	36 h.s.
YSICIAN: The law re toppital or attending certificate has been thed for use os the pt. of Health prior to	lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO Representation of the contribution of the contrib	THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19. WAS AUTOPSY PERFORMED? YES NO
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bing PHYSIC by the hospi After this certi be detroched State Dept. o	Hour o.m. 19 While Not While of work of work	tory, street, office bldg., etc.)	ounty) (Stote)
R ATTENDING retained by the ECTOR: After 3 should be divided the State	21. I certify that (I) (this hospital) attended the deceased frames saw the deceased alive an	at death accurred at ? 4 M, fram causes and on	the date stated above DATE SIGNED
	Of de a la ama	D. ATTENDING DIRECTOR STAFF PHYS. 22d. ADDRESS	117,1967
TO HOSPITAL OR Poge 4 moy be of FUNERAL DIRI director, poge 3 should be filed v	NAME (Type) POBERTE BELL MD 23d. BURIAL, PREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR	187 E. MAIN WEST MU	(County) (Stote)
	B. REMOTIAL ISPACIFY 4 20/67 IESSEE CENT. 24. FUNERAL DIRECTOR OF MAINTENANCE ADDRESS MAINTENANCE TO THE STATE OF THE STA	250. REC'D BY REGISTRAR 250 REGISTRAR'S	SCOTT VA
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1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAN 0499	93
24 hours after death. illed in by the funeral apers. Pages 1 and and 72 hours after death.	1. PLACE DF DEATH a. COUNTY A. STATE b. COUNTY MARYLAND MARYLAND MARYLAND	
nours aft I in by th s. Pages hours aft	b. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) d. NAME OF HDSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS	
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g physician len please ion please ioval, and in	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 14. MOTHER'S MAIDEN NAME	1-
at the death certificat ian. d by the attending phy cransit permit. Then p cremation, or removal,	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 2, 7 - 48 - 0282 Leslie Kamp (Soul Boutemore h	an
ires that the d physician. signed by the burial-transit p burial, cremati	18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cleute my o carshal Farlure 2 for	BETWEEN ND DEATH
ding ding beer the or to	Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO Service Schuric 204.	us.
4: The law recal or attendial or attendial fiftcate has be for use as the Health prior	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 119. WAS	S AUTOPSY FORMED? NO [
PHYSICIAN: The the hospital or a thic because detached for use to be to be bept. of Health		(State)
DING PHY the After the doctor State D	Hour a.m. p.m. 19 While Not While at work factory, street, office bldg., etc.)	~
	saw the deceased alive on 4-26 1967, and that death occurred at 2 MM, from the causes and on the date states a signature 22b. DATE SIGNED	ated above
PITAL OR 4 may be ERAL DIRE or, page 3	22c. PHYSICIAN'S NAME (Type) ATTENDING MED. STAFF DIRECTOR PHYS. 4-26-	4/
TO HOSPITAL Page 4 may TO FUNERAL director, pa	M. C. Porterfield 23a. BURIAL CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial A. C. Porterfield 123c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) Burial 123d. Location (City, town or county) Forest Baptist Cemetery Upperco, Md.	(State)
VR A15 (4)	24. FUNERAL DIRECTOR ADDRESS Tipton - Eline Funeral Home Hampstead, Md. DAMAY 1 1967 Clarks Jud	pe.



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04994 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE PLACE OF DEATH USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) o. COUNTY o. STATE Page 0 Carrel] MARYLAND C. CITY OR TOWN (It outside corporate limits, write RURAL and give nearest town) delay 3 b. CITY OR TOWN (If outside corporate limits, Departmen c. LENGTH OF STAY IN 1b write RURAL and give nearest town) ofter Sykesville 1 day Baltimore d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS hours Office olong with form Springfield State Hospital Item 18. Give Pages ate 911 N. Carrollton Ave. YES | NO L hours ofter death. 3. NAME OF First Middle 4. DATE Dov Year DECEASED JAMES within 7 EDWARD KING April 25 67 (Type or print) 19 DEATH S. SEX 8. DATE OF BIRTH 6. COLOR OR RACE NEVER MARRIED AGE (In years IF UNDER I YEAR IF UNDER 24 HRS 7. MARRIED last birthdoy) Months Doys Hours 10-9-16 Male Negro WIDOWED DIVORCED event 1Do. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (Stote or foreign country) 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? in ony Rug Cleaner South Carolina

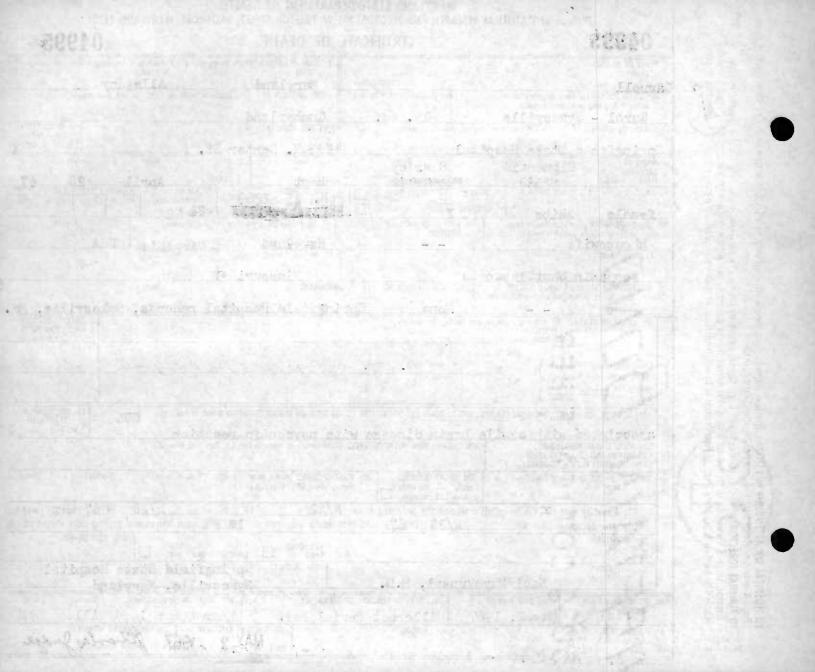
14. MOTHER'S MAIDEN NAME = II.S.A 13. FATHER'S NAME pencil be executed within 0 puo Unknown Mary (Maiden name unknown IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT removal. (Yes, no, or unknown) (If yes give war or dates of service Records, Springfield State Hospital 2118-211-8227 No 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) INTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY ONSET AND DEATH Acute fatty change of the liver. 0 IMMEDIATE CAUSE (o) word certificate should cremotion, DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse 0 last. burial, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? certificate, YES T NO 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) ogent, prior PRIMARY Or CONTRIBUTING CAUSE OF DEATH. 2Dc. TIME OF INJURY Month, Doy, Yeor 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) foctory, street, office bldg., etc.) may be retoined for your FUNERAL DIRECTOR: Page 21. I certify that I took charge of the remains described above, held an Autapsy XI Inspection . Inquiry and in my apinian death resulted from: Natural causes Suicide [Accident Homicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE FO DEPUTY 5 may be TO FUNERAL Heolth or i DEPUTY MEDICAL EXAMINER **EXAMINER'S** Address Atreat with toknion county Lathellela NAME (Type) the 230. BURIAL CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) REMOVAL (Specify) County Md Calvary Cemetry BURTAT 24. FUNERAL DIRECT REC'D BY REGISTRAR VR A15ME (5)

Property of the Secretary and the second of THE STREET STREET The state of the s

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04995 04995 CERTIFICATE OF DEATH in by the funeral ers. Pages I and 2 72 hour after death. requires that the death certificate be executed within 24 haurs after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o COUNTY o STATE b COLINTY b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) **MARYLAND** Maryland
C. CITY OR YOWN (If outside carparote limits, write RURAL and give neorest town) c. LENGTH OF STAY IN 16 Rural - Sykesyille 1v. 6
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1v. 6d Cumberland 52TREET ADDRESS e. IS RESIDENCE ON A FARM? papers. physicion and completely filled en please remove carbon pape NO T YES 🗍 Springfield State Hospital No Center St. 3. NAME OF Claricy Last 4. DATE Year Clomenziest DECEASED 例对前季茶 DEATH (Type or print) April Lambart 9. AGE (In years last birthday) IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE IF UNDER I YEAR 7. MARRIED **NEVER MARRIED** 1889 Manths Days Haurs in ony WIDOWED DIVORCED white female 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired)

Hhousewife COUNTRY? INDUSTRY Maryland West Virginia
14. MOTHER'S MAIDEN NAME USA 13. FATHER'S NAME the offending phys Benjamin Shuttlesworth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? Missouri * Ashby 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, no, ar unknown) (If yes give wor or dates af service) Springfield Hospital records. Sykesville, Md. None crematian, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) buriol-transit ONSET AND DEATH PART I DEATH WAS CALISED BY IMMEDIATE CAUSE (a) signed by DUE TO buriol, Conditions, if any, which gove rise ta immediate cause (a), DUE TO stoting the underlying cause os the TO HOSPITAL OR ATTENDING PHYSICIAN: The low re Page 4 may be retained by the hospital or ottending TO FUNERAL DIRECTOR: After this certificate hos been WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO X associated with senile brain disease with psychotic reaction for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING TI CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, farm, (City or town) (State) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (County) foctory, street, office bldg., etc.) Not While of work at wark 21. I certify that (F(this hospital) ottended the deceased from 4/22 , 19 66 , ta 1/28 , 19 67 that 1 (we) last 1/28 19 67, and that death occurred at 10 PM, fram causes and an the date stated above. sow the deceased alive an_ 22a SIGNATURE 22b. DATE SIGNED ATTENDING DIRECTOR PHYS. PHYS. 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S NAME (Type) Naci Buyukunsal. M.D. Sykesville, Maryland director, 23d. LOCATION (City or Town) (County) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (State) 23a. BURIAL CREMATION. REMOYAL (Specify) Alleg Ma May 2. 1967 Near Cumberland Hillcrest Burial Park 25b. REGISTRAR'S SIGNATURE 2Sq. REC'D BY REGISTRAR VR A15 (4) 20 M 1/66



1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	04996 MEDICAL EXAMINER'S CERTIFICATE OF DEATH DAGGE
HEALTH DEPT.	1. PLACE OF DEATH a. COUNTY ARROLL CO MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE MARYLAND CARROLL COUNTY CARROLL
necessa the fune 5 may epartme	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LIMION BPIDGE RD d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
oo aate aate oo urs	DEEP RUN ROAD OFF ROUTE 140
ny de Ma. Ma. The S	3. NAME OF PIRST Middle Last 4. DATE Month Day Year OF OF DECEASED (Type or print) ROBERT DAVID LEESE DEATH PRIL 22 1967
form 1, If	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 18. DATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24 HRS. Inst birthday) Months Days Hours Min. Months Days Hours Min. Min.
- × × ×	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR life, even if retired) 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?
	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
	CLAYTON J. LEESE HELEN WEIDNER 15. WAS DECEASED EVER IN U.S. ARMED FÖRGES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address.
hin 24 cil in sr's 0 mit. F oval,	(Yes, no, or unknown) (If yes give war or dates of service) 214-36-9641 DANIEL WILESE UNION BRIDGE RD#1
ed within in pencil li xaminer's it permit.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (of) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Security IMMEDIATE CAUSE (a) Security IMMEDIATE CAUSE (a)
xecut ling" cal E cal E trans	976X DUE TO
"ild be executed I "pending" in if Medical Exan a burial-transit I cremation, or i	Conditions, If any, which gave rise to immediate (b)
shoul word Chief as a rial, c	underlying cause last. (c)
icate sho the worn the Chi the Chi used as to burial	PERFORMED? YES NO
certifing ded to the prior	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 13. WAS AUTOUS PERFORMED? YES NO PERFORMED? YES NO PRIMARY BY OF CONTRIBUTING CONTRIBUTING COURSE OF TOTAL CONTRIBUTING COURSE OF DEATH.
NER: This ficate, will be forward see 3 shou id agent,	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY Home, Yarm, Phour a.m. While at work at
the certificate should be a sh	21. I certify that 1 took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident . Suicide V. Homicide , Undetermined manner
EDICAL EXU cute the c age 4 shou r your files DIRECTOR: r its design	CHIEF MEDICAL EXAMINER
EDI cute age age yo DIR	ACTUAL SIGNATURE OF CLEVE OF COLORS DEPUTY MEDICAL EXAMINER 4727-67
	EXAMINER'S NAME (Type) Address (Secont Alacans Colons Buestletarul)
TO BEPUT please director. retained TO FUNER of Health	23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) ST DAVID'S CEMETERY NO HAY OVER PARTY SIGNATURE 24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR'S SIGNATURE
VR A15ME 3500 4-64	J.S. Myers of Westminder, Md. DAMPR 26 1967 Joliantes July

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	MARYLAND	STATE DEP	ARTM	ENT OF H	HEALTH		
STICAL	RESEARCH A	ND RECORDS,	301 W.	PRESTON	STREET,	BALTIMORE 1	, MARYLAND
	CF	RTIFICATE	OF	DEATH			0.400

a. STATE Maryland b. COUNTY Carroll b. GITY OR TOWN If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) we stminster ARAMCE OF BOSTILA CHRISTIUTION (if not in hospital, give street eddress) 14.7 E. Green Street BAME OF FIRST MAND BOSTILLE MANAHAN BAME OF OPINION MAUD ESTELLE MANAHAN SUBJECT OF PORTON SEX G. GLOR OR RACE 7. MARRIED NEVER MARRIED NOV. 27, 1888 78 british 10 prince 14 pri	072330		CERTIFICA	IE OF DEATH		11/1/4/8
D. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ### STEVENS. d. NAME OF DESTITUTION (if not in hospital, give street eddress) ### April 10 (STREET ADDRESS) ### ADDRESS ### April 10 (STREET ADDRESS) ### April	1. PLACE OF DEATH a. COUNTY	7 7		07475	CE (Where deceased lived, If In	stitution: Residence before admission)
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ### STRUMENT and give nearest town) ### STRUMENT A.RAME OF DESTITUTION (if not in hospital, give street eddress) A.RAME OF DESTITUTION (if not in hospital, give street eddress) A.RAME OF DESTITUTION (if not in hospital, give street eddress) A.RAME OF DESTITUTION (if not in hospital, give street eddress) A.RAME OF DESTITUTION (if not in hospital, give street eddress) A.RAME OF DESTITUTION (if not in hospital, give street eddress) A.RAME OF DESTITUTION (if not in hospital, give street eddress) A.RAME OF DESTITUTION (if not in hospital, give street eddress) A.RAME OF DESTITUTION (if not in hospital, give street eddress) A.RAME OF DESTITUTION (if not in hospital, give street eddress) A.RAME OF DESTITUTION (if not in hospital, give street eddress) A.RAME OF DESTITUTION (if not in hospital, give street eddress) A.RAME OF DESTITUTION (if not in hospital, give street eddress) A.RAME OF DESTITUTION (if not in hospital, give street eddress) A.RAME OF DESTITUTION (if not in hospital, give street eddress) A.RAME OF DESTITUTION (if not in hospital, give street eddress) A.RAME OF DESTITUTION (if not in hospital, give street eddress) A.RAME OF DESTITUTION (if not in hospital, give street eddress) A.RAME OF DESTITUTION (if not in hospital, give street eddress) A.RAME OF DESTITUTION (if not in hospital, give street eddress) A.RAME OF DESTITUTION (if not in hospital, give street eddress) A.RAME OF DESTITUTION (if not in hospital) give street eddress	Carr	011	MARYLAND	a. STATE Ma	ryland ". "	Carroll
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143 E. Green Street	Westminster				ster	16.1
143 E. Green St. VES NOE			ospital, give street eddres	d. STREET ADDRESS		e. IS RESIDENCE
DECEASED (Type or print) MAUD ESTELLE MANAHAN SEA G. COLOR OR RACE TO, MARRIED NEVER MARRIED NOV. 27, 1888 S. DATE OF BIRTH S. AGE (In years FUNDER! YEAR FUNDER 24 HRS. NOTHING PRINT Subject Subject NOV. 27, 1888 S. DATE OF BIRTH S. AGE (In years FUNDER! YEAR FUNDER 24 HRS. North of Subject Subject Nov. 27, 1888 TO yrs. S. AGE (In years FUNDER! YEAR FUNDER 24 HRS. North of Subject Subject Nov. 27, 1888 S. DATE OF BIRTH S. AGE (In years FUNDER! YEAR FUNDER 24 HRS. North of Subject Subject Nov. 27, 1888 TO yrs. S. AGE (In years FUNDER! YEAR FUNDER 24 HRS. North of Subject Subject Nov. 27, 1888 TO yrs. S. AGE (In years FUNDER! YEAR FUNDER 24 HRS. North of Subject Subject Nov. 27, 1888 TO yrs. S. AGE (In years FUNDER! YEAR FUNDER 24 HRS. North of Subject Subject Nov. 27, 1888 To yrs. S. AGE (In years FUNDER! YEAR FUNDER 24 HRS. North of Subject Subject Nov. 27, 1888 To yrs. S. AGE (In years FUNDER! YEAR FUNDER 24 HRS. North of Subject Subject Nov. 27, 1888 To yrs. North of Subject North o		n Street		143 E.	Green St.	
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH death. and completely filled in by the funeral remove carban papers. Pages 1 and in any event, within 72 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH o. County Carroll o. STATE b. COUNTY Maryland Baltimore City MARYLAND 24 hours after c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) vrs.10mos.21drs. Baltimore Sykesville e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS 3435 Roland Ave. 12 Springfield State Hospital YES NO X the death certificate be executed within 3. NAME OF Middle 4. DATE Doy Year please remove carban First Lost Month DECEASED OF 1967 SARAH EDITH MAYS MARCH 12 DEATH (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS. B. DATE OF BIRTH AGE (In years SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthdoy) Hours Months Doys 11-10-1882 White Female X DIVORCED or remaval, and in any WIDOWED 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Factory Worker INDUSTRY COUNTRY? attending physician permit. Then please Maryland U.S.A. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Bennett Hoshall Elizabeth Gore 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) 218-09-9789 Records, Springfield State Hospital No crematian, INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the burial-transit p burial, crematic ONSET AND DEATH PART I. DEATH WAS CAUSED BY: The law requires that IMMEDIATE CAUSE (o) Myocardial infarction Hours be retained by the haspital or attending physician. DUE TO Coronary arteriosclerosis Conditions, if ony, which gove Years rise to immediate couse (o), DUE TO stoting the underlying couse as the Page 4 may be retained by the haspital or attending O FUNERAL DIRECTOR: After this certificate has been Years (a) Arteriosclerotic cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO PEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) PSYCHOTIC depressive reaction. WAS AUTOPSY PERFORMED? use Health p NO X for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20e. PLACE OF INJURY (Home, form, (City or town) (County) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED foctory, street, office bldg., etc.) Hour o.m. Not While ot work ot work pe 21. I certify that (1) (this haspital) attended the deceased fram 5-21-59 to 4-12-67 ___, 19____, that (I) (we) last shauld and that death accurred at 1:50 MAHom causes and an the date stated above saw the deceased alive an 4-12-67 19 22b. DATE SIGNED 220. SIGNATURE STAFF PHYS. ATTENDING \mathbf{x} 4-12-67 DIRECTOR M.D. PHYS. director, page 3 should be filed v 22d. ADDRESSSpringfield State Hospital 22c. PHYSICIAN'S Agustin del Campo, M. D. NAME (Type) Sykesville, Maryland 23d. LOCATION (City or Town) 23c NAME OF CEMETERY OR CREMATORY (County) (Stote) 23o. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify)
B urlal Middletown, Middletown Baptist Md. 25b. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR Milarles Judge 1967 VR A15 (4) Tipton- Eline Funeral Home Humpstead, Md. 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05001 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution; Residence before admission) b. COUNTY o. COUNTY o. STATE Carroll Maryland attending physician and campletely filled in by the turner or then please remave carban papers. Pages constructions to the construction of the con MARYLAND requires that the death certificate be executed within 24 haurs after b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c, CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) Sykesville 1 mo. 13 das. Baltimore 27275 d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) e. IS RESIDENCE ON A FARM? d. STRFET ADDRESS Apt. 131 Springfield State Hospital 3905 Edgewood Rd YES NO THE 3. NAME OF 4 DATE Day Year DECEASED (Type or print) MEYERS Harry NMN April 19 67 DEATH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED B. DATE OF BIRTH NEVER MARRIED last birthday) Months Dovs Hours WIDOWED white male 3-41-04 12. CITIZEN OF WHAT Oa. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) during most of working life, even if retired)

**MANNIMAN Real Estate COUNTRY? INDUSTRY Maryland Bondsman II.S.A 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME Mayer Meyers - dec. - dec 17. INFORMANT 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. permit. (Yes, no, or unknown) (If yes give wor or dates of service 219-32-2028 Springfield State Hospital Remords 1B. CAUSE OF DEATH (Enter only one couse per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-transit ONSET AND DEATH Arteriosclerotic cardio-vascular disease. vears IMMEDIATE CAUSE (o) signed by DUF TO Conditions, if any, which gave Generalized arteriosclerosis. (b) vears rise ta immediate cause (a), DUE TO stating the underlying cause as the the hospital ar attending TO FUNERAL DIRECTOR: After this certificate has been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) far use NO 50 Diabetes Mellites. CBS, circulatory disorder, with psychotic reaction. YES 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (Stote) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year factory, street, affice bldg., etc.) Nat While ot work TO HOSPITAL OR ATTENDING Page 4 may be retained by 21. I certify that (I) (this hospital) attended the deceosed from 3-3-67 to 4-16-67, 19 , that (1) (we) last 4-16-67 19 ___, and that death accurred of 11 a.M. fram causes and an the date stated above sow the deceased alive an_ 22b. DATE SIGNED 22a. SIGNATURE ATTENDING MED. DIRECTOR STAFF PHYS. X 4-16-67 PHYS. Springfield State Hospital Sykesville, Maryland 2178 22d. ADDRESS 22c. PHYSICIAN'S Octavio Ruiz, M.D. NAME (Type) directar, shauld be 23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 1/200 Har Sinai Garrisan Maryland
STRAR 256. REGISTRAR'S SIGNATURE 2Sa. REC'D BY REGISTRAR VR A15 (4) 20 M 1/66 Minutes Judge DATEAPR 2

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05002 CERTIFICATE OF DEATH 24 haurs after death physicion ond completely filled in by the funerol en pleose remove carbon popers. Pages 1 and oval, ond in any levest, within 72 hours after deatloval, ond in any levest, within 72 hours after deatloval. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY o. STATE b. COUNTY MARYLAND Maryland
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 Rural - Sykesville 13v.7m.26d. Baltimore City e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS YES T NO [918 E. Chase St. Springfield State Hespital law requires that the death certificate be executed within NAME OF Middle Lost DATE Month Dov Year DECEASED (Type or print) Bella DEATH April Anna Montgomery IF LINDER 1 YEAR SEX B. DATE OF BIRTH AGE (In veors IF LINDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthdov) Months Doys Hours DIVORCED WIDOWED Sept. 13. Female white 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) INDUSTRY USA Mother's helper unknown

14. MOTHER'S MAIDEN NAME the ottending p Heroy Montgomery unknown WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. permit. (Yes, no. or unknown) (If yes give wor or dates of service) 220-54-6601 Springfield Hospital records, Sykesville, Me cremation, INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c),) buriol-transit PART I. DEATH WAS CAUSED BY ONSEL AND DEATH IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse hos been os the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUI NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) CBS associated with disturbance of metabolism, growth or nutrition WAS AUTOPSY PERFORMED? NO I TO FUNERAL DIRECTOR: After this certificate with senile brain disease, with psychotic reaction for TO HOSPITAL OR ATTENDING PHYSICIAN POge 4 may be retained by the hospital of 20d. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) OR CONTRIBUTING CLAUSE OF DEATH o detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. foctory, street, office bldg., etc.) Not While ot work ot work 21. I certify that 41) (this haspital) attended the deceased fram.... Sept. 23., 19 53, to Apr. 29., 19 67, that XI) (we) last Apr. 29. 1967, and that death accurred at 9 A. M, from causes and an the date stated above. saw the deceased alive an. 22b. DATE SIGNED 220. SIGNATURE ATTENDING M.D. DIRECTOR PHYS. director, page should be filed 22d. ADDRESS 77c PHYSICIAN'S Springfield State Hospital NAME (Type) Naci Buyukunsal, M.D. Sykesville. Mi 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) f Med. 709 N. Wolfest. 23o. BURIAL CREMATION. 23b. DATE THEREOF REMOVAL (Specify) 5/3/67 Johns Hopkins School df **ADDRESS** REC'D 8Y REGISTRAR 25b REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Marles

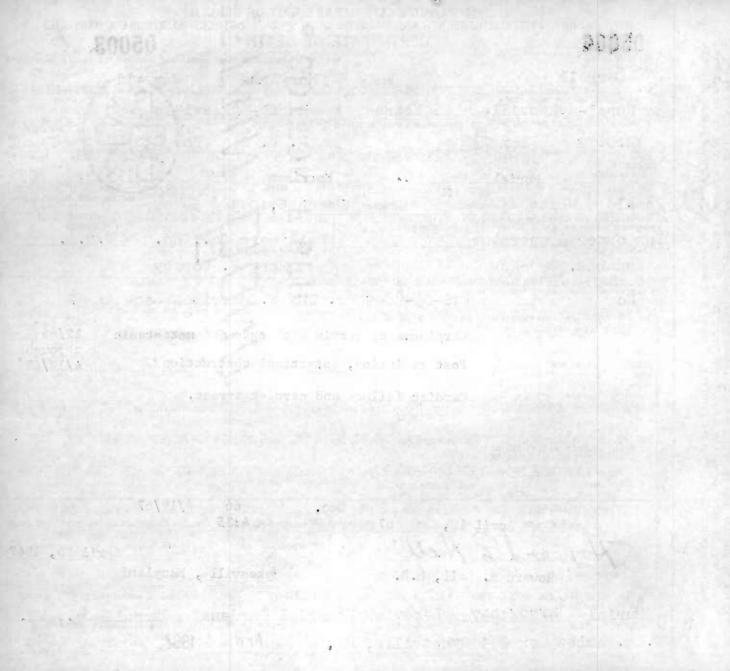
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND SOLO 2

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PLACE OF DEATH a. CDUNTY			CE (Where deceased lived	, If institution: Re	esidence before admission)
Carroll	MARYLAND	a STATE Marylan	đ Ca	, If institution: Re . COUNTY PPO11	V
 CITY DR TOWN (if outside corporate limits, write RURAL and give nearest town) 	c. LENGTH DF STAY IN 1b				and give nearest town)
Rural-Sykesville	6 Years	Rural-	Svkesvill	0 1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in he	ospital, give street address)	d. STREET ADDRESS	O JACOVILLE	0	e. IS RESIDENCE
R.D. 2 Box 232		R. D.	2 Box	232	YES NO A
3. NAME OF First	Middle	Last	1 4. DATE	Month	Day Year
DECEASED (Type or print)	Middle		OF DEATH		
5 OFF PURIEL	U.	Morrison B. DATE OF BIRTH	10 ACE (In	April 1	9. 1967 LYEAR JIF UNDER 24 HRS
7. WARRIED	MEASU MAKKIED		last birt	hday) Months	Days Hours Min.
Female White Widowed		arch 5, 19	ounty & State, or foreign	yrs.	TIZEN DF WHAT
during most of working life, even if retired)	NDUSTRY			CD	UNTRY?
Inn owner & operator 13. FATHER'S NAME			e Co., Md	. U.	S.A.
		14. MOTHER'S MAIL			
Frank C. Crooks			V. Dorse		
(Yes, no, or unknown) ((If yes nive war or dates of service)		INFORMANT		Address	
No 21	6-05-8849 Mr	. Guy W.	Morrison	Same As	#2
18. CAUSE OF DEATH [Enter only one cause per li	ine for (a), (b), and (c).]				INTERVAL BETWEEN
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca	rcinoma of cer	vix with ex	tended meta	stasis	12/66
17/X DUE TO	LOTHOMA OF COT	722 772 011 011		00000	through
	st radiation,	intestinal	obstruction		4/19/67
gave rise to Immediate	00 14,				
underlying course test	rdiac failure	and cardiac	arrest.		
				VEN IN PART 1(a)	19. WAS AUTOPSY
					PERFORMED?
PARTII. OTHER SICNIFICANT CONDITIONS CONTRIBUTED 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	DESCRIBE HOW INJURY OCCU	RRED. (Enter nature o	f inlury in Part I or Pa	rt II of item 18.	
20a. ACCIDENT WAS UNDERLYING 20b. E CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,		
	NJURY OCCURRED 20e. PLA	CE OF INJURY (Home, fa	arm, 20f. (City or to	wn) (Cour	ntv) (State)
20c. TIME DF INJURY Month, Day, Year 20d. II Hour a.m. While p.m. 19 at work	Not While factor	y, street, office bldg., e	tc.)	(0001	(Otato)
	at work		1 120	1/5	
21. I certify that (I) (this hospital) attended	ed the deceased from \Box				, that (I) (we) last
saw the deceased alive on April 19	, 19 6.7 and that	death occurred at_	4:3M, from the ca		
22a. SICNATURE	1014	ATTENDING	MED STAFF		TE SICNED
Howard 5 1	tall M.D	. PHYS.	MED. STAFF PHYS.	Apr:	il 20, 1967
22c. PH/SICIAN'S NAME (Type) Horrord F Hol	.1, M.D.	22d. ADDRESS	sville, Mar	vland	
Howard E. Hal	L, MeDe	Dyke	.072240,	7	
23a. BURIAL, CREMATION, 23b. DATE THEREDF REMDVAL (Specify)	23c. NAME OF CEMETERY	OR CREMATORY	23d. LOCATION (City, town or cou	nty) (State)
Burial 4/22/1967	Lakeview Me	emorial Ga	rdens C	arroll	Co. Md.
24. FUNERAL DIRECTOR	ADDRESS	25a. RE	C'D BY RECISTRAR 2	b. REGISTRAR'S	
C. M. Waltz Box 241 Sy	kesville, Mo	. DATE AL	K 2 4 1967	ychan	les jugge
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DEBOVA BY	era crownen .a				

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, crematian, or remaval, and in any event within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital ar attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

	05005		CERTIFICATE	OF DEATH		0500	5
	1. PLACE OF DEATH a. COUNTY Carrol.	l, Maryland	MARYLAND	I CTATE	Where deceased lived, if institutes b. COUR	ion: Residence bef	fore odmission)
	b. CITY OR TOWN (If autside write RURAL and give ne (Rural) Syke	arest tawn)	c. LENGTH OF STAY IN 16 10y. 7m. 26d		itside carparate limits, write RUI Ltimore		est tawn) e. IS RESIDENCE
18		d State Hospi			E. 32nd. St	reet	ON A FARM? YES NO X
	3. NAME OF DECEASED (Type or print)	First Charles	Middle William (last D'Neill	4. DATE Mont		ay Year 19 67
	S. SEX 6. COLO	DR OR RACE 7. MARRIED WIDOWED		3. DATE OF BIRTH	9. AGE (In years last birthday) 76 yrs.	Months Days	IF UNDER 24 HRS.
	10a. USUAL OCCUPATION (Give kir during most of working life, even	if retired) IN	ND OF BUSINESS OR DUSTRY Pilot on ship	11. BIRTHPLACE (County	& State, ar fareign country)	12. CITIZEN COUNTR'	
1	John R. O'Ne			14. MOTHER'S MAIDEN	NAME : Lastner		
	1S. WAS DECEASED EVER IN U.S. / (Yes, no, or unknown) (If yes giv	ve wor or dates af service)	004	NFORMANT Ospital Rec	Addre	ess	
S. Seller	PART I DEATH WAS (IMEDIATE CAUSE (o) PULMO	(a), (b), and (c).) Onary Emphyser	na			NTERVAL BETWEEN ONSET AND DEATH 3 yrs
1	Conditians, if ony, which g	(a), ()	onic Bronchiti	İs			years
	stating the underlying callast.	(c) Gene	eralized arter				years
2	Chronic bra	ain syndrome	o DEATH BUT NOT RELATED TO T associated wi	th psychot	ic reaction,		9. WAS AUTOPSY PERFORMED? YES NO
	OR CONTRIBUTING CAUSE	OF DEATH	SCRIBE HOW IMJURY OCCURRED.	Enter noture of injury in	Port I ar Part II of item 18.)		
10	20c. TIME OF INJURY Mon Haur a.m. p.m.		Not While facts	CE OF INJURY (Home, form pry, street, affice bldg., etc.)		(County)	(Stote)
1	21. I certify that saw the deceased		ded the deceased fram_ 19_67_, and that	8-74, 1 death accurred at	56 , ta 4-10 11:50 fram causes	, 1%7 , and an the d	that (1) (we) las ate stated abave
1	220. SIGNATURE M	aris E. E	Ermal M.		MED. STAFF DIRECTOR PHYS.		10-67
1	22c. PHYSICIAN'S NAME (Type) Mag	rio E. Comas,	M.D.		pringfield Skesville, Mar	ryland	spital
	23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Apr. 13,1967	23c. NAME OF CEMETERY OR Holy Redeemen		23d. lOCATION (City or To	Maryland	
5	24. FUNERAL DIRECTOR Wm. Cook-Brook	cs Towson, 105	ADDRESS 50 York Road wson, Md, 2120	ADD		GISTRAR'S SIGNAT	

Towson,

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FOR STATE	05006 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05001	6
HEALTH DEPT.	PLACE OF DEATH	e before admission)
~= co / +**	Carroll Maryland Baltimore C	itv
lay is necessary, i 3 to the funeral Page 5 may be State Department ours after death.	b. CITY OR TOWN (If outside corporate limits, write RURAL and g write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and g	ive rearest town)
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Page State hours	Springfield State Hospital 579 Laurens St. 3. NAME OF First Middle Last 4. DATE Month Day	YES NO X
PM3. Pm3. h the St.	DECEASED (Type or print) HATTIE SYLVIA PARKER DEATH APRIL 20	19 67
4	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR	Hours Min.
rs after death. If 18. Give Pages 1. along with form ages 1 and 2 with n any event within	Female Negro WIDOWED I DIVORCED 4-7-1889 78 yrs.	
er deal ive Par with with l and l	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN COUNTRY	Y?
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n 18. Gi		
Item Item Office and	John Myers Bertha Wilson 15. WAS DECEASED EVER INU.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address	
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NER. This certificate should be executed within 24 hours after death. I ficate, writing the word "pending" in pencil in Item 18. Give Pages be forwarded to the Chief Medical Examiner's Office along with forn 3 should be used as a burial-transit permit. File pages 1 and 2 Wid agent, prior to burial, cremation, or removal, and in any event with	1.18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)]	ERVAL BETWEEN SET AND DEATH
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ild be executed "pending" in if Medical Exan burial-transit i	4221 DUE TO	
be e pend fedio	Conditions, if any, which gave rise to immediate (b)	
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writi writi ardec ould t, pr		(State)
EXAMINER: This cartificate, writhould be forward les. R: Page 3 shoul signated agent, p.	Hour a.m. While Not While factory, street, office bidg., etc.)	(01010)
MINE ld be Page nated		nd in my opinior
AL EXAMINATE Certification of the certification of	21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , ar death resulted from: Natural causes , Accident , SuicIde , Homicide , Undetermined manner	ia iii iiiy opiiiioi
the the company of the des	CHIEF MEDICAL EXAMINER	
EDICAL Cute the age 4 sh your fill DIRECTO	SIGNATURE ACTUAL M.D. ASSISTANT MEDICAL EXAMINER [2. DATE SIGNED
TAL TO L	DEPUTY MEDICAL EXAMINER S	1 de a
DEPUTY MEDI please execut director. Page retained for yo D FUNERAL DIR of Health or it	EXAMINER'S W. Glenn Speicher, M. D. Address (Street Atty County County) 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county)	Ligitates
of H	BEMOVAL (Specify) 4/21/1967 Berlever Cemeters derinton Men	reduced
- 190	24. FUNERAL DIRECTOR 556 ADDRESS Street 5a. REC'D BY REGISTRAR 1/25b. REGISTRAR'S SIG	NURE
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PLACE OF DEATH	Carroll		MAR	YLAND	o. STATE	ENCE (Wh	ere deceased	lived. If institut b. COUNTY		roll	odmission)	}
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OR INSTITUTION	Nursing Hom				G. STREET A	JORESS .					ON A FA	RM?
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Female	T.Tlo d de o	MARRIEI	NEVER MARR		Mar. 5,			9. AGE (In years last birthday) 90 yrs.	Months	Days H		4 HRS. Min.
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Housewij	fe					er, N			U	.S.A.		
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200. ACCIDENT V OR CONTRIBUTION (IF EITHER, NOTICE)	WAS UNDERLYING 1 2 NG CAUSE OF DEATH FY MEDICAL EXAMINER)	0b. DESCR	IBE HOW INJURY	OCCURRED.	(Enter nature of	injury in P	Part I or Part	II of item 18.)				
20c. TIME OF INJ Hour a. m p. m	none 10	20d. INJ While al work [Nat while at work	20e. PLAI fact	CE OF INJURY (Hory, street, affice	lame, form, bldg., etc.	20f. (City	or town)	(Caunty)		(Stote)
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BURIAL, CREMAT REMOVAL (Speci	TION, 226. DATE THEREOF		22c. NAME OF CEN	METERY OR			22d. LOCAT	ON (City, town, ysville,	or county)	o. M	(Stote)	
FUMERAL DIRECTION		New I	ADDRESS Vindsor,	Md.		240, REC'I	D BY REGISTE	RAR 246, REGI	STRAR'S SI			

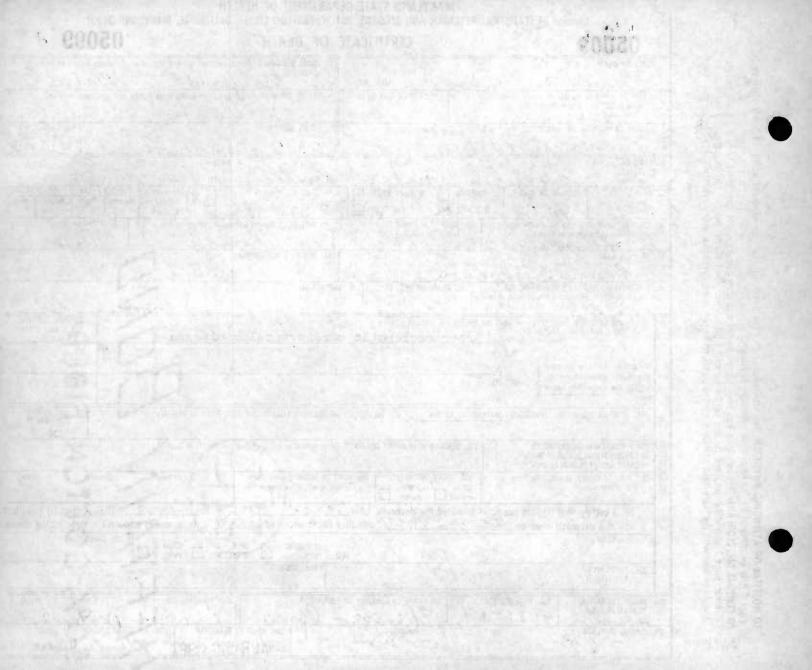
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death. Page 4 me entained by the hospital or attending physician. O FUNERAL D. CIOR. After this certificate has been signed by the attending physician and completely fills by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO HOSPITAL OF death. Page 4 m

MARYLAND STATE DEPARTMENT OF HEALTH

	DIVISION OF STATISTICAL RESEAU 05008	CERTIFICAT		STREET, BALTIMOR	E 1, MARYLAND
1.	PLACE OF DEATH		2. USUAL RESIDENCE	(Whera deceased lived, If insti	tution: Residence before edmission)
	a. COUNTY		e. STATE mand	b. COUNTY	Carroll
	b. CITY OR TOWN (if outside corporate limits,	MARYLAND c. LENGTH OF STAY IN 1b		autside corporate limits, write RL	
	write RURAL end give nearest town)	C. LENGTH OF STAT IN ID	some /	4	TAL BIN GIVE HEETEST TOWN,
_	mancheste	7 clays		stead	OLO 1
1	d NAME OF HOSPITAL OR INSTITUTION (if not in hos	pitel, give street address)	d. STREET ADDRESS	0	IS RESIDENCE ON A FARM?
	mathew terraing to	me Juci	117 Ca	rroll st	YES NO
3/	NAME OF First	Middle	Lest 4.	DATE Month	Day Yeer
-	(Type or print)	P	letres/	DEATH 1	17 1967
5.	SEX 6. COLOR OR RACE 7 MARRIE	D NEVER MARRIED 8.	DATE OF BIRTH	9. AGE (In years IF	UNDER I YEAR IF UNDER 24 HRS.
1	11 0 110 4	- INCIDENTAL MARKIES	41171 00	last birthday) M	onths Deys Hours Min.
1 10	Male While WIDOWE		1/23/ 81	18 4 yrs.	
	a. USUAL OCCUPATION (Give kind of work 10b. Ki	IND OF BUSINESS OR INDUSTRY	M1. BIRTHPLACE (County &	& State, or foreign country)	12. CITIZEN OF WHAT COUNTRY
12	ock installer		Maltimo	re, ma.	454
13.	FATHER'S NAME		14. MOTHER'S MAIDEN NA	ME	
14	William I (+1)	treas	LOUKA	Kelly	
15.	WAS DECEASED EVER IN U.S. ARMED FORCES? 16.	SOCAL SECURITY NO. 17. II	NFORMANT	Address	
(1)	ns, no, or unkown) (If yes give we ror detes of service)	3-05-5358AM	An Cillan	. a Beel	man
-	18. CAUSE OF DEATH [Enter only one cause per li		in incorpa	C. Nacc.	I INTERVAL BETWEEN
	PART I. DEATH WAS CAUSED BY:	1 . 11	1: 11 1	0	ONSET AND DEATH
	IMMEDIATE CAUSE (a)	Tern som	ru c-v.	meme	10410.
	DUE TO				
	Conditions, if eny, which (b)				
	geve rise to immediate cause				
	tal, stating the underlying				
7	PART IL OTHER SIGNIFICANT CONDITIONS CON	TRIBUTING TO DEATH BUT NO	RELATED TO THE TERMINAL	DISEASE CONDITION GIVEN	IN PART 1(e) 1 19. WAS AUTOPSY
CERTIFICATION	Carlons on ton S	an many	1 / 1/12 //	Frm this	PERFORMED?
2	Crocker (VIII)	rop or years	1 0100 00		, YES NO
1	OR CONTRIBUTING CAUSE OF DEATH	CRIBE HOW INJURY OCCURED.	(thier neture of injury in Perf	Tor Part II of item 18.)	
1.	(IF EITHER, NOTIFY MEDICAL EXAMINER)				
MEDICAL			CE OF INJURY (Home, farm,	20f. (City or town)	(County) (Stete)
<u>a</u>	Hour a.m. While et work	THOI WHITE	iry, sirear, office bidg., etc.)	,	
1	21. I certify that (I) (this hospital) attend	dad the despeed from	3-78 19	1 10 4-17	, 19.,, that (I) (we) las
				,.,	
	saw the deceased alive on	19, and that	death occurred and	/M, from the causes and	
	22a. SIGNATURE	1111/	ATTENDING MED	STAFF	22b. DATE SIGNED
	on. C. O www.	M.		CTOR PHYS.	4-17-67
	22c. PHYSICIAN'S NAME (Typa)		22d. ADDRESS	1. /	mil
-	reame (Typa)		Son	sorean	11/10
23	a. BURIAL, CREMATION, 23b. DATE THEREOF	23c. NAME OF CEMETERY C	OR CREMATORY	23d. LOCATION (City, town	or county) (State)
	REMOVAL (Specify)	Evengreen Memo	rial Gardens	Finksburg Car	roll Co. Md.
1	Burial 4/20/67 FUNERAL DIRECTOR'S SIGNATURE	Evergreen Memo		BY REGISTRAR 25b. REGIS	
24			and Dr		liance Judge
,	Tipton - Eline Funeral Hor	me Hampstead, N	Id. DATE AFT	1 4 0 1301	1

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2 1	MARYLAND STATE DEPARTMENT OF HEALTH OF Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARY	LAND
FOR STATE	05010 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	2010
HEALTH DEPT.	1. PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence of the country	nce perore admission)
- 0 + :	Carroll Maryland Carrol	1
is necessary, or the funeral e 5 may be. Department after death.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster C. LENGTH OF STAY IN 1b C. CITY OR TOWN (If outside corporate limits, write RURAL and Rural Taneytown	give nearest town)
necess: the fund 5 may Departm	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS d. STREET ADDRESS	OG,
Page 19 Page 10 Page 20 Page 2	Carroll County General Hospital Route # 1M	ON A FARM?
delay is nd 3 to Page State hours a		Day Year
Mas Mas	OF CTYPE OF PINT) EARL David ROOP DEATH 4- 9	1967
F. 12 1	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (in years FUNDER 1 YE last birthday) Months Day	AR IF UNDER 24 HRS.
d 2 de la fo	Male White WIDOWED DIVORCED 9/18/1903 63 yrs.	
er deal	during most of working life, even if retired) INDUSTRY COUNT	
ours aft. n 18. G a along pages 1 in any	Farmer Farming Carroll Co., Maryland U.S. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	A
nours am 1 ce a ce a d in	George W. Roop Berta Nogle	
24 ho n Item Office Office File , and	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) ((fyes give war or dates of service)	
within pencil in miner's permit.	No 219-36-1146 Mrs. Mary Agnes Roop, R# 1M, Taneyt	
It EXAMINER: This certificate should be executed within 24 hours after death. If the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, should be forwarded to the Chief Medical Examiner's Office along with form files. TOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with faciliansted agent, prior to burial, cremation, or removal, and in any event within	PART I, DEATH WAS CAUSED BY:	NTERVAL BETWEEN
cute Fx. In ansid n, or	W201 IMMEDIATE CAUSE (a) CONCURRY / MANAGEMENT WALLY	reverence (
"pending" In "pending" In f Medical Exan burial-transit cremation, or	Conditions, If any, which (Croundy delegate	1900
id be "pe f Me buri	gave rise to immediate cause (a), stating the DUE TO	/
shoul vord Chief as a rial, (underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19. WAS AUTOPSY
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ntiffice to the total to the total t	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 2Da. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH.	
R: This celerate, writing forwarded 3 should agent, privagent, pri	PRIMARY Or CONTRIBUTING CAUSE OF DEATH.	
te, te, orwe	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED thour a.m. While at work at	(State)
intica intica be f ge 3 ed a		1.1
LEXAMINEINE CERTIFICS should be filles. TOR: Page designated a		and in my opinion
NEDICAL EXUCUTE the Coute the Cage 4 shour ryour files DIRECTOR:	death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner CHIEF MEDICAL EXAMINER	J
MEDICA ecute t Page 4 or your L DIREC or its o	ACTUAL SIGNATURE CHECK PERIOD ASSISTANT MEDICAL EXAMINER	22. DATE SIGNED
o de	DEPUTY MEDICAL EXAMINER	Parago
EPUT asse sector ained unker Healt	NAME (Type) / W. Glenn Speicher Address English day by mile construction 23a. Burial, cremation, 23b. Date thereof 23c. Name of Cemetery or Crematory 23d. Location (City, town or county	(Stale)
de direction	REMOVAL (Specify)	Maryland
(9)	24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S S	IGNATURE
VR A15ME 35DD 4-64	John M. Skille C.O. Fuss & Son, Taneytown, Md. DATE 1 1 1 St. flanker	udge.

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certificate physician YLAND STATE DEPARTMENT OF HEALTH

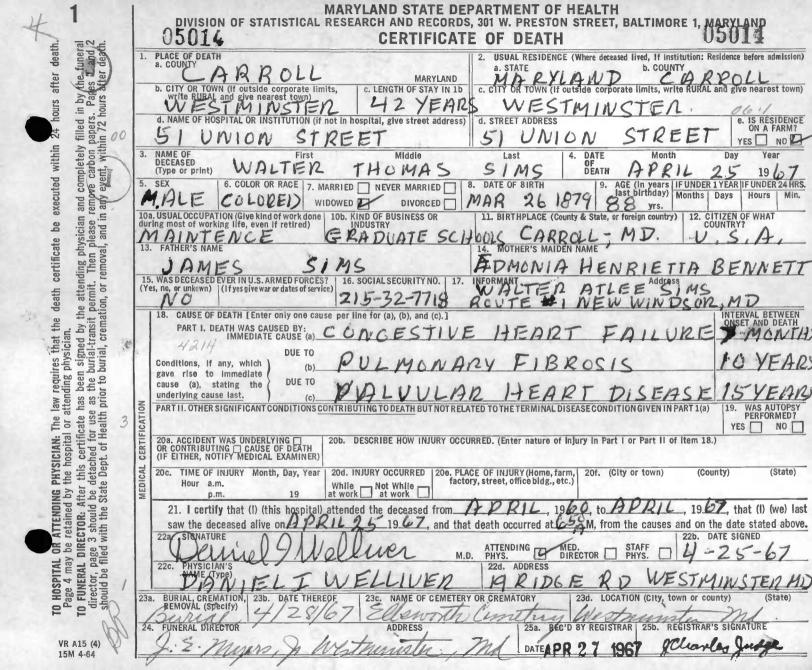
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05012 CERTIFICATE OF DEATH 05012 deoth. 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH the attending physician and completely filled in by the funeral sit permit. Then please remove carbon papers. Pages 1 and b. COUNTY a. COUNTY Carroll MARYLAND requires that the death certificate be executed within 24 hours after flarro 77 T. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) bon papers. Pages I within 72 hours after b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c LENGTH OF STAY" IN 1b > Route#2 Finksburg 6 mo's. 39das. Sykesville e. IS RESIDENCE ON A FARM? d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) Springfield State Hospital YES NO V 4 DATE 3 NAME OF Middle Day Year Last DECEASED 19 67 DEATH April 30 Shauck (Type ar print) Wesley Jarrett IF UNDER I YEAR IF UNDER 24 HRS. 9. AGE (In years 8. DATE OF BIRTH 6. COLOR OR RACE NEVER MARRIED 7. MARRIED last birthday) Manths Days Haurs Wh tite WIDOWED DIVORCED ond in ony 7-20-91 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind af wark dane 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) COUNTRY? during mast af warking life, even if retired) INDUSTRY Maryland Butcher 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME or remavol, Eliza Barber William Shauck 17 INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, na, ar unknown) (If yes give war ar dates af service 218-32-2664-A Records, Springfield State Hospital No crematian, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a)? (b), and (c).) signed by the buriol-tronsit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY nemone IMMEDIATE CAUSE (a) physician. DUE TO buriol. Canditians, if any, which gave rise ta immediate cause (a). **DUE TO** stating the underlying cause hos been s by the hospital or attending os the last. prior 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NO certificote Far 205 DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part 1 or Part II of item 18.) 20g. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CIT CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) (Caunty) 20e. PLACE OF INJURY (Hame, farm, (City ar town) (State) 20d. INJURY OCCURRED 20c. TIME OF INJURY Manth, Day, Year O FUNERAL DIRECTOR: After this factory, street, affice bldg., etc.) Haur a.m. Not While at wark at wark . to_4/30/67 21. 1 certify that (1) (this haspital) attended the deceased fram 10/11/66 19 _. 19___, that (I) (we) last be retoined 1967, and that death occurred of 15PM, fram causes and an the date stated abave. saw the deceased alive an 22b. DATE SIGNED 22a. SIGNATUR ATTENDING N M.D. DIRECTOR director, page should be filed 22d. ADDRESS Springfield State 22c. PHYSICIAN'S 21784 Sykesville, Maryland NAME (Type) Connor Jr 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) 23a. BURIAL, CREMATION 23b. DATE THEREOF REMOVAL (Specify) 2Sa. REC'D BY REGISTRAR 25h. KERISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR _ADDRESS VR A15 (4) 1967 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

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2	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	05013 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05013
HEALTH CEPT.	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission
	a. COUNTY CARROLL MARYLANO B. STATE NARYLANO B. COUNTY CARROLL
ary, eral be be tent ath.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY DR TOWN (If outside perporate limits, write RURAL and give nearest town)
cess fun may artm r de	WESTMINSTER 20 YRS. WESTMINSTER
Dep affe	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS e. IS RESIDENCE DN A FARM?
delay w. Tecessary, nd 3 to the funeral Page 5 may be State Department hours after death.	49 PENNA, AVE. 49 PENNA, AVE. YES NOE
any delay is "ecessary, 2, and 3 to the funeral PM3. Page 5 may be the State Department of 72 hours after death.	3. NAME DF First Middle Last 4. DATE Month Day Yeer DECEASED (Type or print) MAZIE PAULINE SHIPLEY DEATH APRIL 12 1967
PM PM	The Late of the La
ith. If all ges 1, 2 form P within	the state of the s
Page ith 1	10a, USUAL DCCUPATION (Give kind of work done) 10b, KIND OF BUSINESS OR 11, BIRTHPLACE (State or foreign country) 12, CITIZEN OF WHAT
Give Give Manual 1 and 1 and 1 and 1 and 1	HOUSEWIFE & DOMESTIC WORKER BALTIMORE MD U-S.A.
ours after deat n 18. Give Pag e along with pages 1 and 2 in any event	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
24 hour Hitem Office File pa	WILLIAM SUMMERS MAMMIE PAULINE!
24 in It offi	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service) 16. SOCIAL SECURITY ND. 17. INFORMANT Address THINE Y TOWN
l within 2 pencil in miner's 0 permit. I	1.18. CAUSE DE DEATH (Enter only one cause per line for (a), (b), and (c), 1
d w n pe amin t pe r rei	PART I. DEATH WAS CAUSED BY: ONSET AND DEATH
uld be executed 1 "pending" in sf Medical Exam a burial-transit i	1201 IMMEDIATE CAUSE (a) DUE TO
e exe indin dica ial-tr	Conditions, if any, which (b)
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shoul vord Chief as a	underlying cause last.) (c) (C) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPS OF THE PROPERTY OF THE PROPER
EXAMINER: This certificate should be executed within 24 hours after death. If any del the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and should be forwarded to the Chief Medical Examiner's Office along with form PM3. files. **TOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Sidesignated agent, prior to burial, cremation, or removal, and in any event within 72 ho	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION C
tiffic for to	20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)
ritin ritin rded uld k	20a. EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) CAUSE OF DEATH.
ER. This certificate, writing forwarded to 3 should be agent, prior	3 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State)
NER: Fication for the formal de against the second	Hour e.m. p.m. While at work at work at work
AMIII to lid to	21. I certify that I took charge of the remains described above, held an Autopsy, Inspection 🔀, Inquiry, and In my opinion
he ce shoul files.	death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined manner
re 4 te t Vour REC	ACTUAL CONTROL OF ACTUAL CHIEF MEDICAL EXAMINER () 22. DATE SIGNE
TY MEDICAL EXECUTE T. Page 4 d for your RAL DIRECT Its or its c	DEPUTY MEDICAL EXAMINER
bon VERA	Address (Street Elly, Chown Lor Journally Market Types
TO DEPUTY MEDICAL EXAMINE please execute the certific director. Page 4 should be retained for your files. TO FUNERAL DIRECTOR: Page of Health or its designated	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county)
P - P M	24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR'S SIGNATURE 25b. REGISTRAR'S SIGNATURE
VR A15ME	2-5-mers Ja Most muster, Md- DATE APR 17 1967 golianles Justille
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REAR WEST OF STREET ARROLL CARROLL WESTMINSTER 2019S WESTMINSTER 49 PENNA, AVE. 49 PENNA, RUE MAZIE PROLINE SHIPLEY IN APRIL 12 67 FEMALE WHITE - JUNE 8, 1890 76 HOUSEWIFE & DEDIESTIE NERKER EALTIMORE ND. USE WILLIAM SOMMERS FAMMIE PAULINE! 213-28-1742 RELPH 6-54 19284 , ATTRUBAL The said was the said the said of the said ELRIPT A LIZA KELDEUS CEMELEN LIEZLANDELES NO 25 myer Je Watninger, M.

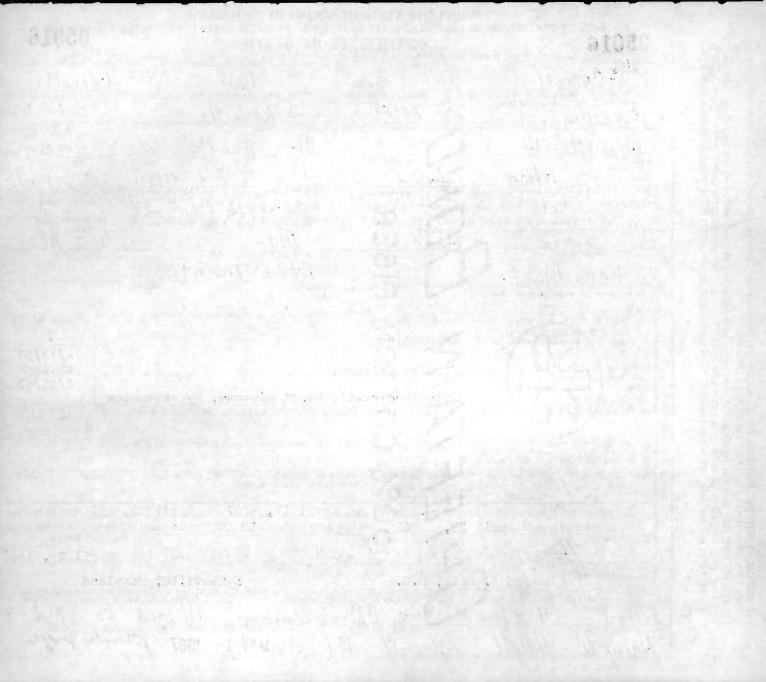


Fest with the CARROLL LARRENA CARROLL WESTIGINSTELL HZ YEARS WESTININGTER SI Union STREET SI UNION STREET WALTER THOMAS SIMS ON APRIL 25 LT MALE COLUMN WAR 26 1879 98 MAINTEACE GRADUATE SCHOOLS CARROL; MV. U.S. A. JAMES STAS ADAGNIA HEKRIETIA BENKETE NO 215-32-718 ACUTE OF NEW WINDSON, NO CONCESTIVE HEART FAILURE & MONRIE PULMONARY FIBROSIS 10 VENE PIDLULIAR HEART DISEASE IS YEAR Deniel Halling 1 100 11 25-61 DANIEL I WELLIER HEIDER RO VESTIMISTER HI See The Standard Contract of the See The See Standard Contract of the See

MARYLAND STATE DEPARTMENT OF HEALTH

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199		DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MA	WALAND O
	E A TOPE	05016 CERTIFICATE OF DEATH	02019
	full and ter death.	1. PLACE OF DEATH a. COUNTY CACCOL MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If Institution: Res a. STATE M. C. OUNTY CA D. COUNTY CA	Idence before admission
24 hours filled in by appers. Pa	by the Pages urs after	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. CLENGTH GF STAY IN 1b C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	nd give nearest town)
	hou	. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	8. IS RESIDENCE ON A FARM?
	MArriotts ville Road Marriotts ville Rd-	YES NO	
	rted within completely ve carbon event, with	OF April & They Stanton DEATH April &	Day Year 23, 1967
	and and and and and	DIVORCED 6 20 /9/6 50 yrs.	ays Hours Min.
	d icia asserind	Howard of working life, even it retired) INDUSTRY	IZEN OF WHAT
	eath certificat attending phy ermit. Then p m, or removal,	William Muers 14. MOTHER'S MAIDEN NAME Etta Thornton	
	uires that the death completed by the attend in signed by the attend burial-transit permit burial, cremation, or respectively.	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) (If yes give war or dates of service)	
	ne do	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
	rat the cian. sed by trans trans, crea	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia	
	res that the obsician. Signed by urial-transiourial, cremonial, cr	Conditions, If any, which (b) Cardiac failure.	4/17/67 through
	required inding property speem so the property in the property is the property in the property	gave rise to Immediate cause (a), stating the underlying cause last. DUE TO Arteriosclerotic heart disease, Hypertension	4/23/67
	ICIAN: The law requires that the death certificate ospital or attending physician. certificate has been signed by the attending physical for use as the burial-transit permit. Then ple to death prior to burial, cremation, or removal, a to	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 20a. ACCIDENT WAS UNDERLYING [19. WAS AUTOPSY PERFORMED?
	PHYSICIAN: the hospital this certifi detached fo e Dept. of H		
	O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by director, page 3 should be detached for use as the burial-transhould be filed with the State Dept. of Health prior to burial, or the contraction of the	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Hour a.m. While at work at work at work at work	ty) (State)
	rtained trained TOR: At should th the S	21. I certify that (I) (this hospital) attended the deceased from April 17, 1967, to April 23, 1967 saw the deceased alive on April 23, 1967, and that death occurred at 10 A M, from the causes and on the	, that (I) (we) last e date stated above
•	O HOSPITAL OR ATTEND Page 4 may be retained O FUNERAL DIRECTOR: 4 director, page 3 should should be filed with the	The state of the s	il 25, 196
	O HOSPITAL Page 4 may O FUNERAL director, pa	22c. PHYSICIAN'S 22d. ADDRESS Sykesville, Marylan	d
	TO HO Page direction	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or coun REMOVALI (Specify) 4-27-67 PAISY Chorch Cemetery Howard Co.	Md.
	VR A15 (4)	24. FUNERAL DIRECTOR ADDRESS 25a. REG'D BY REGISTRAR 25b. REGISTRAR'S DATMAY 1 1967 Policy Park Dat MAY 1 1967	SIGNATURE
	20M 1/65		



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05017 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE Page b. COUNTY ta Carroll MARYLAND -Baltimore City delay 3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, C. LENGTH OF STAY IN 1b and write RURAL and give nearest town) M3. Baltimore lwr-9mos.18dvs Sykesville d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Der ate De Springfield State Hospital 2926 Harford Rd. ar Give Pages NO X YES 3. NAME OF First Middle Lost 4. DATE Month Doy Yeor DECEASED OF **JESSE** LEMOYNE with the TITUS (Type or print) APRIL DEATH 19 S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS lost birthdoy) Months Doys Hours Male White WIDOWED 3 DIVORCED Item] event/ pup 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or fareign country) 12. CITIZEN OF WHAT during most of working-life, even if retired) INDUSTRY COUNTRY? pages I Steam fitter
13. FATHER'S NAME Plumbing & Contracting Pennsylvania U.S.A 14 MOTHER'S MAIDEN NAME Samuel Titus Ammie Paul File pup 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service 16 SOCIAL SECURITY NO. 17. INFORMANT permit. removal, No 234-03-3595 Records, Springfield State Hospital CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY ONSET AND DEATH Pulmonary embolism. ar IMMEDIATE CAUSE (o) ward should crematian, DUE TO Conditions, if ony, which gove Phlebothrombosis of periprostatic venus plexus. Days writing the rise to immediate couse (a) DUE TO 0 stoting the underlying couse farwarded Fracture of left femur. Week used as burial, a last. 19. WAS AUTOPSY PERFORMED? PART LI OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) CBS assoc. with circulatory disturbance other than cerebral the certificate, arteriosclerosis, with neurotic reaction YES 3 pe 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item IB.) 20a. EXTERNAL CAUSE WAS prior 3 shauld PRIMARY [or CONTRIBUTING shauld Fell in bathroom & was unable to get up. **EXAMINER:** CAUSE OF DEATH 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, Springfield State Hospital M Ward, Men's Crup Sykesville Carroll Md. at work of work designated 21. I certify that I taak charge of the remains described above, held an Autopsy Inspection | Inquiry and in my apinian Natural causes death resulted fram: Accident X Suicide [Hamicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER SIGNATURE TO DEPUTY pe 10 DEPUTY MEDICAL EXAMINER **EXAMINER'S** W. Glenn Speicher, M. D. Add ss) Sheet, My Llever of county Health NAME (Type) 23b, DATE THEREOF 5/3/67 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, 23d. LOCATION (City or Town) (County) 0 REMO, VAL (Specify) Meadowridge Mem. Park Cem. Dorsey, Md. 7922 Wise Ave. Dundalk, Md. 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 2Sa. REC'D BY REGISTRAR John J. Duda, VR A15ME (5) 6M 1/66

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should	1-)	COUNTY	SUAL RESIDENCE (Where deceased lived, if institution: Re STATE () b. COUNTY	sidence before edmission)	
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or de la	1	write RURAL and give nearest town)	Stat. md.	12,2	
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ud ir		James Townsley	anne Kohe		
en p	15.	NAS DECEASED EVER IN U.S. ARMED FORCES? 114. SOCIAL SECURITY NO. 17. INFOR	MANT Address		
- P	110	, no, or unkown) (Ifyes give war or deles of service) 2/8 - 0.3-2268 m.	s Loce Phipps (Loughter) me	wheater, me	
re .		18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)	0	ONSET AND DEATH	
Ö		PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cenebral Vana	war accedent	10 days	
1 O 1		1/221 DUE TO 6 +	- Cambia Massalan	1 dans	
E S		Conditions, if eny, which geve rise to immediate cause	ie caracter of a state	11-40	
, <u>le</u>		(a), stating the underlying DUE TO	Record		
1	Z	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA	TED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART	1(e) 19. WAS AUTOPSY	
3 5	CATION	Dighetes mellities		PERFORMED?	
D. J. C.	F	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter OR CONTRIBUTING CAUSE OF DEATH	nature of injury in Part I or Pert II of item 18.)		
£	8	(IF EITHER, NOTIFY MEDICAL EXAMINER)			
Ď.	SE	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm, 20f. (City or town) (State) Hour a.m. 20f. (City or town) (County)			
<u>o</u>	WED	p.m. 19 at work et work		/= 4	
Dep		21. I certify that (1) (this hospital) attended the deceased from 3/30, to 4/1, to 4/1, that (1) (we) last			
State		saw the deceased alive on			
بر م م			ATTENDING MED. STAFF PHYS. DIRECTOR PHYS.	4/15/6 SIGNED	
with t		22c. PHYSICIAN'S	22d. ADDRESS	11,00	
d view	1	NAME (TYPO) W. It FOATA M.D	MANCHESTER, M	4 21102	
0 4	23	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CR	1	- 00	
8.8	1	BURIAL MAP, 18,1961 EMORY	STREET, HARF		
A15 (4)	24	22 FUNERAL DIRECTOR'S SIGNATURE ADDRESS APR 19 1967 256, REGISTRAR'S			
A 7-62		form 11. Havens DELIA, PA.	DATE	0_0	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the timeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after Page 4 may be retained by the hospital or attending physician.

VR AI5 (4) 20M I/65 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05019

CERTIFICATE OF DEATH
05019

		UI				
1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived, If institution: R	esidence before admission)				
Carroll	a, STATE b. COUNTY					
MARTLAND	Maryland Baltimore					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	c. CITY OR TOWN (If outside corporate limits, write RURAL	and give nearest town)				
Rural-Sykesville 15 Years	Baltimore 03.7					
d. NAME DF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	d. STREET ADDRESS	e. IS RESIDENCE				
		DN A FARM?				
Ross Nursing Home	3508 Ellen Road	YES NO D				
3. NAME DF First Middle	Last 4. DATE Month	Day Year				
DECEASED	0F					
(Type or print) Sarah	Wagner DEATH April 2	1967				
5. SEX 6. CDLOR OR RACE 7. MARRIED NEVER MARRIED	8. DATE OF BIRTH 9. AGE (In years LIF UNDER	1 YEAR HE UNDER 24 HRS.				
Homo70 Whosto	last birthday)	Days Hours Min.				
Female White WIDDWED DIVORCED	Aug. 8, 1872 94 yrs. Months	Taylor I III III				
10a, USUAL OCCUPATION (Give kind of work done 10h, KIND OF RUSINESS OR		ITIZEN OF WHAT				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY	CI	DUNTRY?				
Housewiff	Frederick Co., Md. U.S.A.					
13. FATHER'S NAME	1 - 1 COCT TOW OO . MO. 1 O.	U.M.				
	14. MOTHER'S MAIDEN NAME					
John Buxton	Sally Brangle					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17.						
(Yes, no, or unkown) (If yes give war or dates of service)	INFORMANT Rt. 2 Mt.	Aim= 1/3				
	Man (17 17 17	Airy, Md.				
	Mr. Charles W. Wagner					
18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN				
PART I. DEATH WAS CAUSED BY:	1 4 4 .	ONSET AND DEATH				
IMMEDIATE CAUSE (a) Arteriosclerosis,	generalized;					
4200 DUE TD	4/8/67					
	4/0/0/					
Conditions, If any, which) (b) Arteriosclerotic	heart disease,	through				
gave rise to immediate DUE TD		1 100 167				
couse (a), stating the	4/22/67					
underlying cause last.) (c) Cardiac failure,	bronchial pneumonia.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA	ATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19. WAS AUTDPSY				
TV.	1120 10 1112 1 211111111112 10 10 10 2 0 0 10 11 10 11 10 11 11 11 11 11 11 11	PERFORMED?				
2		YES NO				
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20a. ACCIDENT WAS UNDERLYING DESCRIBE HOW INJURY OCCU DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	ARED. (Enter nature of injury in Part 1 of Part 11 of Item 18.	,				
(IF EITHER, NOTIFY MEDICAL EXAMINER)						
3 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLA	CE OF INJURY (Home, farm, 20f. (City or town) (Cou	nty) (State)				
E Have a m	CE OF INJURY (Home, farm, 20f. (City or town) (Cou bry, street, office bidg., etc.)	nty) (State)				
While Not While	13, 3d cet, office blug., etc.)					
p.m. 19 at work at work						
21. I certify that (I) (this hospital) attended the deceased from 4	/8/ 19 67 to 4/22/ 19 6	that (I) (we) last				
south descend alive on 1/100/ 10.67 and that	t death occurred at 11P M, from the causes and on the	data stated above				
22a. SIGNATURE		ATE SIGNED				
Herenaux > 8/all	D. ATTENDING MED. STAFF DIRECTOR PHYS. ADT:	1 00 1067				
HOMPHU CO HALL M.D		il 23, 1967				
22c. PHYSICIAN'S	22d. ADDRESS					
NAME (Type) Howard E. Hall, M.D.	Sykesville, Maryland					
23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY	OR GREMATORY 23d. LOCATION (City, town or cou	inty) (State)				
REMOVAL (Specify) 4/25/1967 Marvin Cha	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	211				
		· Md ·				
24. FUNERAL DIRECTOR ADDRESS 25a. REGISTRAR 25b. REGISTRAR'S SIGNATURE						
C. M. Waltz Box 241 Sykesville, Md. DATE APR 26 1967 Charles Judge						
1000 11	DATE					

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MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05021 DEATH OF requires that the death certificate be executed within 24 hours ofter death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence befare admission) attending physician ond completely filled in by the funeral sermit. Then please remake carbon papers. Pages Tagd PLACE OF DEATH a. COUNTY a. STATE b. COUNTY Carroll Maryland Carroll MARYLAND b. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) Rural Westminster Rural Westminster d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) e. IS RESIDENCE ON A FARM? 00 within Route # Route # YES NO X 3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE Manth Year Day Susan Weishaar April 19 67 Grace DEATH S. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED last birthday) Manths Days Haurs and in any WIDOWED DIVORCED July 30. 1904 Female White 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during mast af warking life, even if retired) INDUSTRY COUNTRY? Housewife Maryland

14. MOTHER'S MAIDEN NAME II.S.A Own home 13. FATHER'S NAME Charles Marquet Flora Lambert 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknawn) ((If yes give war ar dates af service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address 220-46-7859 7 Westminster, Md. Carroll Weishaark R 18. CAUSE OF DEATH (Enter anly one cause per line (ar. (a), (b), and (c).) INTERVAL BETWEEN burial-tronsit PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (a) DUF TO Canditians, if any, which gave rise ta immediate cause (a), DUE TO stating the underlying cause TO HOSPITAL OR ATTENDING PHYSICIAN: The low re Page 4 moy be retoined by the hospital or attending TO FUNERAL DIRECTOR: After this certificate hos been os the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? be detached for use State Dept. of Health p YES NO 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Hame, form, (City or town) (State) 20c. TIME OF INJURY Manth, Day, Year (County) factory, street, affice bldg., etc.) Nat While at wark 21. I certify that (I) (this hospital) attended the deceased from the deceased of the deceased olive on 1944, and that death accurred at 1950 M, from causes and on the dote stated above. ploods sow the deceased olive on_ 22a. SIGNATURE 22b. DATE SIGNED **ATTENDING** DIRECTOR M.D. director, poge should be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) E. Reese Wilkens 15 Kemper Ave., Westminster, Md 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a. BURIAL, CREMATION (County) (State) REMOVAL (Specify) Buria April 26,1967 Baust Cemetery Tyrone. Carroll Co. N 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 2Sa. REC'D BY REGISTRAR VR A15 (4) Ochanter Judge 1967 C.O. Tuss & Son 20 M 1/66 Taneytown, Maryland

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CERTIFICATE OF DEATH funeral 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institutions a. COUNTA b. COUNTY a. STATE Urro MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 WNV(If outside corporate limits, write RURAL and give nearest town) 함 write RURAL and give nearest town) 10 Arrcholn d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) REET ADDRESS papers. n 72 hor completely 9. NAME OF Middle Last 4. DATE Month DECEASED OF (Type or print) DEATH Within carbon 6. COLOR OR LACE 7. MARRIED NEVER MARRIED 5. SEX AGE (In years IF UNDER 1 YEAR 8. DATE OF BIRTH last birthday) and Months WIDOWED DIVORCED 10a! USUAL OCCUPATION Give kind of work 1Db. KIND OF BUSINESS OR INDUSTRY Гетоуе (County & State, or toreign country) done during most of working life, even if retired 13. FATHER'S NAME MOTHER'S MAIDEN NAM ā 15. WAS DECEASED EVER IN U.S. ARMED FORCES? SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) | (If yas give war or detes of service) 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: une IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which (b) gava rise to immediate cause DUE TO (a), stating the underlying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CERTIFICATION 0 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Pert I or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, 20f. (City or town) Month, Day, Year factory_street, office bldg., etc.) While Not While Hour a.m. et work at work D. m. 21. I certify that (I) (this hospital) attended the deceased from Mas. 10 1961 saw, the deceased alive on 22a. SIGNATURE ATTENDING STAFF PHYS. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN BURIAL CREMATION, 1 236. DATE THEREOF LOCATION 23c. NAME OF CEMETERY OR CREMATORY town or county REMOVAL (Specify) 24 FUNERAL DIRECTOR'S SIGNATURE EC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE VR A15 15M 7-62

MARYLAND STATE DEPA

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

e. IS RESIDENCE

Year

IF UNDER 24 HRS.

Hours

INTERVAL BETWEEN

ONSET AND DEATH

PERFORMED?

(County)

NO

(State)

22b. DATE

(State)

SIGNED

12. CITIZEN OF WHAT COUNTRY?

Day

ON A FARM? YES NO

83020

28 DE 5

7201 13

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05024 06526 FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEP PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) n COUNTY o. STATE Page 0 MARYLAND Baltimore City Carroll delay b. CITY OR TOWN (If outside corporate limits. C LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corporate limits, write RURAL and give negrest town) write RURAL and give nearest town) Baltimore Sykesville mos.28dvs. d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? haurs 1818 E. Fairmount Ave. Springfield State Hospital Item 18. Give Pages YES NO X haurs after death. Office along with 3. NAME OF Middle 4 DATE Last Month DECEASED JACK PROFITT WINTERS APRIL 29 (Type ar print) DEATH S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED last birthday) Months Dovs Haurs 2-22-17 WIDOWED DIVORCED Mala White 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT during mast af warking life, even if retired) INDUSTRY COUNTRY? in any Plumber/Painter = North Carolina II.S.A 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME be executed within pencil William Winters (last name unk. Abbie 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT (Yes, na, arunknawn) (If yes give war ar dates of service) 1941-1945 Yes 556-18-3209 Records. Springfield State Hospital IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH ar Bronchopneumonia IMMEDIATE CAUSE (n) Ward certificate should crematian, DUF TO Conditions, if ony, which gove Pyelonephritis Days rise ta immediate cause (o). DUE TO stoting the underlying couse SD PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? Alcoholism (addiction) the certificate. YES X 20g. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) shauld agent, priar PRIMARY Or CONTRIBUTING CAUSE OF DEATH 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) Haur a.m. factory, street, office bldg., etc.) While Nat While may be retained Tar your FUNERAL DIRECTOR: Page of work at wark 21. I certify that I took charge of the remains described above, held on Autopsy Inspection Inquiry and in my apinion death resulted from: Natural couses of Accident Suicide [Hamicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER SIGNATURE L DEPUTY MEDICAL EXAMINER **EXAMINER'S** Address Atreet scitt byp, or jounty NAME (Type) TAL Glenn Speidber. M 230. BURIAL CREMATION NAME OF CEMETERY OR CREMATORY LOCATION (City or Town) (County) 50 REMOVAL (Specify) 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR VR A15ME (5)

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MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Ttems 23 OF DEATH 05025 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) PLACE OF DEATH o. COUNTY Carroll b. COUNTY Maryland Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND the attending physician and campletely filled in by the sit permit. Then please remove carban papers. Pages nation, ar(emovel, and in any event, within 72 haurs after c. LENGTH OF STAY IN 1b PHYSICIAN: The law requires that the death certificate be executed within 24 hours aft b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural -- Sykesville 5vr. 10mo 1741. Baltimore and venue e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS YES NO X Springfield State Hospital 1802 Woodbourne Avanue 4. DATE 3. NAME OF Middle Lost Doy Year DECEASED 1967 Wood Tessie April Mary (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 9. AGE (In years 6. COLOR OR RACE NEVER MARRIED B. DATE OF BIRTH 7. MARRIED TR last birthdoy) Months Doys Hours 1-3-01 WIDOWED DIVORCED White Female 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT COUNTRY? 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INDUSTRY Baltimore, Maryland Housewife 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Mary Elizabeth Shilgon William H. Clark 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, no. or unknown) (If yes give wor or dotes of service) Springfield Records, Sykesville, Md. none INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)
PART 1. DEATH WAS CAUSED BY: cremat burial-transit ONSET AND DEATH IMMEDIATE CAUSE (o) signed by DHE TO burial, Conditions, if ony, which gove neu mo me rise to immediate couse (o), DUE TO stoting the underlying couse 4 may be retained by the haspital ar attending as the TO FUNERAL DIRECTOR: After this certificate has been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) far use Health NO T 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (County) (Stote) 20d. INJURY OCCURRED (City or town) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. Not While of work foctory, street, office bldg., etc.) of wark 21. I certify that (1) (this haspital) attended the deceased from June 3. 19 61, to April 20, 19 67, that (# (we) last P saw the deceased alive an April 19. 1967, and that death occurred at: 15A.M, fram causes and an the date stated above. 22b. DATE SIGNED 22o. SIGNATURE ATTENDING PHYS. directar, page 3 shauld be filed v M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S 50 6120 NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 23b. DATE THEREOF 23o. BURIAL CREMATION REMOVAL (Specify) Raltimore, Md. Parkwood 250. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 136 VR A15 (4)

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CERTIFICATE OF DEATH 1. PLACE OF DENTH 2. USUAL RESIDENCE (Where decased lived, if institution: Residence before edmission) a. COUNTY b. COUNTY · MARYLAND b. CITY OR TOWN (if outside corporeta limits, c. LENGTH OF STAY IN 16 OR TOWN (If outside corporata limits, write RURAL and give nearest town) write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (if not In hospital, give street address) d STREET ADDRESS . IS RESIDENCE ON A FARM YES NO NAME OF 4. DATE Middla Month Day DECEASED OF 196 7 (Type or print) DEATH MMCHMAN and cor carbon nt, withii 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH last birthday) Months Days Hours NOV.10,18 event, WIDOWED 2 DIVORCED remove 10a: USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12, CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME attending 16. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.1 Address (Yes/no, or unkown) | (Ifyes give wer or dates of service) INTERVAL BETW 18. CAUSE OF DEATH Enter only one cause par line for (all (b), end (c). ONSET AND DEATH PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO Conditions, if any, which (6) gava rise to immadiata causa DUE TO (a), stating the undarlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)) 19. WAS AUTOPS CERTIFICATION PERFORMED? 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of itam 18.) OR CONTRIBUTING TI CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20a. PLACE OF INJURY (Homa, farm, 20f. (City or town) (County) (Stata) 20c. TIME OF INJURY Month, Day, Year factory, streat, office bldg., atc.) While Not While Hour a.m. at work | et work | saw the deceased alive on... 22b. DATE 22a. SIGNATURE SIGNED **ATTENDING** STAFF DIRECTOR PHYS. PHYS. death. Page 4. 22c. PHYSICIAN 22d. ADDRESS rector, MAME OF CEMETERY OR CREMATORY 23d. LOCATION (City town or county) (State) 23a BURIAL, CREMATION, 23b DATE THEREO 0.58 REC'D BY REGISTRAR 256. REGISTRAR'S FUNERAL DIRECTOR'S SIGNATURE VR A15 15M 7-62

PYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS.

301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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